

Mental health issues of refugee children: lessons from Croatia

European Child & Adolescent Psychiatry

March 2017, Volume 26, Issue 3, pp 377–381

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ESCAP Communication

First Online:

22 December 2016

DOI (Digital Object Identifier): 10.1007/s00787-016-0924-4

Cite this article as:

Maršanić, V.B., Franić, T. & Ćurković, K.D. Eur Child Adolesc Psychiatry (2017) 26: 377. doi:10.1007/s00787-016-0924-4

Erratum to: Eur Child Adolesc Psychiatry

DOI 10.1007/s00787-016-0924-4

Unfortunately, due to a technical error the article's title was not correctly included in the metadata of the first online publication.

The correct article title is as follows:

Mental health issues of refugee children: lessons from Croatia

The Original Article has been updated.

Croatia, like many other countries in Europe and the Middle East, has experienced the recent refugee/migration wave for several years. However, with the exponential increase in the number of migrants and refugees in 2014 and 2015, the Balkan region became a key transit route into the countries of northern Europe. During 2015 and the first three months of 2016, more than 800,000 refugees have entered Croatia. Like other Balkan countries, the vast majority of refugees were from Syria, followed by Iraqis and Afghans. For the majority of them, Croatia was a country of transit into the Western European countries.

Past experience of implementing psychosocial programs for refugees during the 1991–1995 war in Croatia and Bosnia—Herzegovina

Croatia also faced with population displacement recently. During the 1991–1995 war more than 500,000 people from Croatia were forced to flee their homes and live either with host families or in different centers and camps. The war in Bosnia—Herzegovina aggravated the refugee crisis even more, as over one million found temporary or semi-permanent shelter in Croatia. By the end of 1993, the displaced or refugee population represented more than 20% of the total population of Croatia, which was 4.8 million [1].

The displaced population faced severe traumatic events, and provision of somatic and mental health care represented a major concern. The Ministry of Health of the Republic of Croatia established the Crisis Headquarters in 1991 [2]. Professionals from various medical branches were assigned the task of organizing different departments. Health facilities, from hospitals to rehabilitation centers and primary health care units, were all involved in the provision of health care. The Mental Health Department of the Medical Corps Headquarters was established in August 1991 [2].

From the very beginning in 1991, many different psychosocial programs for traumatized persons were organized by Governmental Organizations (GOs) and non-Governmental Organizations (NGOs). To improve coordination, evaluation, and supervision of different forms of psychosocial help, the Government organized in 1994 the psychosocial help network, which was the beginning of the National Program of Psychosocial Help to War Victims [2, 3]. According to the community-based approach, the psychosocial support was delivered to places where the displaced persons lived (host families or collective centers and camps), in collaboration with the World Health Organization and United Nations International Children's Fund (UNICEF). Following the pyramidal model, a gradual application of psychological and social help programs was provided according to the type of trauma, intensity of the reactions, and life circumstances. These provisions included:

1. (1)

Basic biological and emotional needs (food, medication, and clothes, crisis psychological interventions and urgent psychiatric help)

2. (2)

Activities in the community (nonspecific psychological help)

3. (3)

Specific psychological help and counseling (psychosocial teams for psychosocial help)

4. (4)

Psychiatric care (institutionalized psychiatric help) and finally

5. (5)

Coordination and operative planning on a national level.

In the beginning of the war, mental health professionals in Croatia had no significant experience in working with persons psychotraumatized in war. However, mental health workers quickly adapted to the situation and learned about post-traumatic stress disorder and other psychological disturbances related to war trauma, while they were working with the traumatized persons. Their work included:

1. (1)

Protection of chronic psychiatric patients in war.

2. (2)

Provision of psychological and psychiatric help to members of the Armed Forces: psychiatric care for soldiers with acute psychological problems, psychological and psychiatric help to the wounded on the surgical wards and rehabilitation centers, prevention of inadequate psychological reactions and disorders.

3. (3)

At the same time, there was provision of psychological and psychiatric care to displaced persons, children's mental health care, and education.

4. (4)

Work also included scientific research, publications, and other activities, such as psychological and psychiatric care for ex-prisoners of war.

All this was done in collaboration with other institutions and their respective health services, such as the Ministry of Defense and the Ministry of Internal Affairs.

Emergency interventions for displaced children and youths included the provision of a regular feeding and sleeping routine, the presence of a family member and the avoidance of family separation. The children were also given the opportunity to express their feelings through play, drawings or in the case of older children with verbalizing; and were encouraged to talk about their nightmares and traumatic experiences to family members and to professionals. This was done without pressure, while educating parents and caregivers to tolerate regressive behavior for a certain period of time, but also fostering positive coping and selfcontrol [3–5].

Child mental health care during and after war included emergency psychosocial support to displaced children and their families, children of veterans, children of deceased parents, wounded youths, requiring prolonged medical care and rehabilitation, psychoeducation for parents and caregivers, family interventions, screening for mental health problems of the affected children in schools by school personnel and by school doctors during regular examinations, referral, and continuous clinical treatment for children with severe traumatic disturbances or mental health problems [3–5]. Interventions were applied with the consent of parents or the caregivers whenever possible, taking into account the children's age, traumatic experiences, as well as the level of family and social support.

Knowledge and skills of pediatricians, school doctors, school personnel, social workers about mental health of traumatized children and young were limited. Therefore, an extensive training of professionals who were in direct contact with the refugee and psychotraumatized children was undertaken by mental health professionals [4].

From the Croatian experience during the last 25 years, it became evident that in working with acutely traumatized youths and their families, it is important to prevent the development of severe mental problems and to foster integration and normal development. Successful rehabilitation and resocialization of psychotraumatized youths can only be achieved by intensive and well-timed treatment [4].

The Crisis Headquarters of the Ministry of Health of the Republic of Croatia remained permanently in operation, organizing medical and psychosocial care in different crisis situations throughout years. Another case was the great floods of 2014, in various parts of the country, when large numbers of people had to leave their homes.

Mental health care during recent refugee crisis in Croatia

With such experience from recent past, the Croatian Health and Social Care Services adapted very well to the circumstances created by the recent refugee crisis. However, there were significant differences between the past and the actual situation that had to be considered and confronted in the present. The majority of refugees were males, 14% were women, while 25% were children and adolescents. The majority of children traveled with parents and family, but some were unaccompanied, accidentally or deliberately separated from their own families.

Several collective centers and camps have been organized (Opatovac, Ježevo, Čepin, Zagreb, Sisak, Beli Manastir, Kutina) and a winter transit center has been built in Slavonski Brod in November 2015. Transit centers provided living accommodation and health care including emergency and primary health care through mobile health teams that have been established in collaboration with the Ministry of Health and participating humanitarian partners. People with severe health conditions were referred to appropriate secondary services. Protocols for the medical examination of the refugees, protection against infectious diseases, and a list of necessary medicines and medical equipment were created [6]. Health care public services are accessible without any charges to the refugee population. Examinations and treatment of all health problems were provided by certified clinicians, and in accordance with national regulations.

Of the 554.703 migrants that have entered Croatia by December 31, 2015, 21.694 received health care [6]. 355 emergency health care teams provided 4.343 interventions, and 485 family physician teams provided 16.130 interventions. 591 people were referred for hospital treatment, and among them 3 children required prolonged intensive care. Similar to other EU countries with the recent refugee influx [7, 8], the most common physical health problems of the refugees were respiratory infections (32%), feet injuries and skin problems (22%), general weakness and fatigue (7%), hypothermia (6%), complications of pregnancy (5%), dehydration (4%), diarrhea (3%), and other health problems (2%) [6].

Migrants were not a homogenous group. Therefore, the provision of health care was necessarily influenced by the demands of people from many different cultures. Trained interpreters from the countries of origin were involved. In fact, the interpreters had a more comprehensive role as cultural mediators, serving as intermediary between a displaced person and a service provider, using knowledge of the values, beliefs, and practices within the specific cultural group, along with the knowledge of the different care systems in the Croatian context.

Psychosocial interventions for traumatized refugee children and families

Signs of psychological and social distress in children and adolescents are extremely diverse and depend on the age, traumatic experiences but also family and social support a child has during a crisis situation [5, 9]. Younger children usually display feeding and sleep problems, separation anxiety, speech problems or mutism, temper tantrums, regression in their behavior (thumb sucking, enuresis). School children may experience guilt, somatic complaints, intrusions, nightmares, separation anxiety, fear for the family members and the future, confusion, behavioral problems (shouting, crying and throwing or breaking things), hyperactivity, tension, war-related play. Adolescents may become overwhelmed with feelings of guilt and shame, anxiety, revenge, withdraw from others, exhibit premature adult behavior, or display patterns of behavior with drug abuse, delinquency, and violence.

Factors of importance for the psychological health of migrant children and teenagers include individual dispositional factors, family cohesion, family support, and parental psychological health [10]. Attachment to a caring adult is a key

protective factor for children in response to distress. Therefore, it is important that children are kept with their parents in all kinds of circumstances. Where families have become separated, family reunification services were contacted. Where family reunion was not possible, alternative care arrangements were made in the best interest of the child and provided the option of returning to the family or extended family as a priority.

As parents and care givers are struggling to cope with emotional distress, they may feel overwhelmed from the responsibility of caretaking. Thus, youths are obliged to look for other means of support. Many refugee children and adolescents, witnessing the stress and the suffering of their parents, do not want to disclose their emotional problems to them, fearing that they will overburden them. Therefore, the assessment of the mental health of parents and caregivers is of extraordinary importance. They must be offered psychological support or even clinical referral when they find it difficult to cope with a crisis situation [10].

For the clinical mental health professionals, such as psychiatrists and clinical psychologists—but also volunteers—it is critical to realize that their migrant clients' (both adults and children), understanding and manifestation of psychosocial (un)well-being and mental illness is rooted in their social, cultural, and religious contexts. Volunteers and clinical mental health professionals, such as psychiatrists and clinical psychologists, need to be familiar with this and integrate in assessment questions on the local modes of expressing distress and understanding symptoms to be more accurate and appropriate. Moreover, it is also important to assess whether the person has social dysfunction, as well as strength and coping abilities.

Most individuals, including children and adolescents, experiencing acute mental distress following exposure to extremely stressful events are best supported by psychological first aid (PFA). All aid workers, and especially health workers, were able to provide basic PFA. PFA is not an emergency or clinical psychiatric intervention and is very different from psychological debriefing in that it does not necessarily involve a discussion of the event that caused the distress [11]. Rather, it is a supportive response to a fellow human being who is suffering and who may need support. PFA encompasses: protection from further harm, identification of basic practical needs and ensuring that these are met, providing the opportunity for survivors to talk about the events (but without pressure: listening patiently in an accepting and non-judgemental manner), conveying genuine compassion, discouraging negative ways of coping (specifically discouraging coping through use of alcohol and other substances), encouraging participation in normal daily routines (if possible) and use of positive means of coping (e.g., culturally appropriate relaxation methods, accessing helpful cultural and spiritual supports), encouraging, but not forcing, company from one or more family member or friends, and—as appropriate—offering the possibility to return for further support.

Focused psychosocial support, both emotional and practical, was provided through individual, family, and group interventions to those youths and families who had difficulty in coping. This was delivered by trained non-specialized workers in health, education, and community series, and with ongoing supervision. As migrants were “on the move”, conventional psychotherapeutic interventions needed to be adapted to the fact that the first time you see a person may be the last [11]. Thus, the use of trauma-focused single-session interventions and talk about difficult experiences outside a stable, clinical context was not encouraged. In general, multiple session psychological therapies should only be considered when the person is in a stable situation.

Unaccompanied children (those who have been separated from their family or caregivers during the move) and children that started their journey unaccompanied but were currently traveling with people represented a significant portion during the recent refugee crisis. This was common with the other EU countries receiving migrant population [10]. Identification and registration of these children needed special attention, to enable their protection and save their lives. Unaccompanied children can be exposed to abuse, violence, and exploitation.

Therefore, they are particularly vulnerable to mental health problems. An assessment of these children should include documenting their traumatic experiences, how they react to them and how these affect their mental health/psychosocial well-being [10]. Community-based psychosocial support was offered to these children, but some needed referral to clinical services due to severe mental problems (severe depression, deliberate self-harm, suicide threats

and attempts, aggressive behavior, psychotic reactions, pervasive refusal syndrome), as it has been observed in other countries [12–16]. In contrast, neurotic disorders (ICD-10 F40–48) that required outpatient psychiatric treatment were more common in the youth refugees that were with their families [5, 9].

From past experience with psychosocial interventions for refugee children during war, it was evident that for children and adolescents it is important to organize appropriate opportunities for active play, stimulation, and socialization [3, 4]. These may help to mitigate the negative psychosocial impact of crisis situations. Activities need to be tailored to the children's age, gender, and culture. To minimize distress, children require a sense of routine and participation in culturally relevant normalizing activities. Safe areas for care-giver/child interaction and play have also been organized. Children with special needs required special attention and were also included in care activities, games, and social support.

Staff and volunteers providing assistance to refugees and migrants on the move have been repeatedly exposed to tales of terror and personal tragedy. They live and work under physically demanding and unpleasant working conditions, characterized by heavy workloads, long hours, lack of privacy, and personal space. These stressors may have adverse consequences on their mental health and psychosocial functioning such as anxiety and depressive feelings, psychosomatic complaints, over-involvement with beneficiaries, callousness, apathy, self-destructive behavior (such as alcohol or other substance abuse), and interpersonal conflicts. Supervision was obligatory for all professionals and volunteers providing support or intervention to refugees and migrants [2, 4]. Team managers monitored their staff, through informal observation and periodic routine inquiry, as well as by organizing informal or formal group stress evaluation sessions.

Conclusion and recommendations

Refugees and displaced people from Middle East countries (Syria, Iraq and Iran), Asia, and Africa constitute a highly diverse population in terms of religious, ethnic, linguistic, and socio-economic backgrounds. Levels of psychological stress were high among youth, women, men, and elderly transiting Croatia. Psychosocial and clinical interventions need to go along with interventions to mitigate difficult living conditions [2, 4]. The primary goal of psychosocial interventions delivered to displaced people is to improve the mental health and psychosocial well-being. Mental health practitioners' involvement with youths and their families should be focused on initial support and crisis resolution in the short term. On the other hand, they must also address long-term risks and consequences, arising from the profound losses and ongoing daily stressors that many displaced persons and refugees' experience [2–4].

The most important factors in reducing psychological morbidity in refugees, particularly in children and adolescents, are: (1) planned and integrated rehabilitation programs and (2) attention to social support and family unity [3, 4]. Psychosocial interventions should consist of a multi-layered system of services and supports including those focusing on community-based psychosocial activities with non-clinical backgrounds based on social or community work and also on clinical practitioners with advanced training in mental health [2–4, 11].

Although there is significant lack of manpower and services in CAP in Croatia, it became evident that the child and adolescent mental health and allied professionals during the recent refugee crisis leadership and participated actively in psychosocial interventions either through supervisions of volunteers and non-clinical professionals or clinical evaluations and treatment of youth in a need, thanks to their expertise and their abundant experience.

Supportive and caring attitude of mental health professionals toward young refugees and their families is important and can prevent suffering now and in the future, as it can lessen the burden of trauma and attachment disorders not only on their long-term psychosocial functioning, but also on our community.

Besides their continuous education and improving their knowledge and skills in assessment and treatment of young refugees with mental health problems, mental health care professionals need to teach social workers, teachers, and other non-clinical professionals on mental health needs and problems of young refugees, so

that they can incorporate it in their daily work. It is necessary that mental health professionals develop new and/or update existing guidelines for working with traumatized children and parents in the time of crisis [10].

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