Executive Summary

Rapid Assessment of Mental Health, Psychosocial Needs and Services for Unaccompanied Children in Greece

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BACKROUND

In September 2017, there were approximately 2,850 unaccompanied children (UAC) in Greece among which 1,096 were accommodated in 50 UAC shelters and 240 in 8 safe zones nationwide. Of the total of 8,987 UAC who were referred to EKKA from 1 January 2016 to 30 September 2017, 93% were boys and 7% were girls while 94% were older than 14 years old.[1] During this period, there were increased reports by UAC shelter providers of mental health concerns among UAC, including stress-related aggressive behaviour, high levels of anxiety, depression or acts of self-harm and/or increasing incidents of high-risk behaviour. Challenges to accommodate and respond to the increased case load of UAC, combined with the limited availability of child and adolescent focused mental health services nationwide, raised questions among authorities and child protection actors about the most appropriate mode of response.

In April 2017 UNICEF commissioned a rapid assessment of mental health and psychosocial support (MHPSS) needs and services for unaccompanied children (UAC) in Greece, in order to inform planning for expanded MHPSS services.[2] The **objectives** of the assessment were:

- To assess the *range, scope and scale* of mental health issues facing UAC in Greece;
- To *map existing MHPSS and child protection legislation, policies and services* in Greece and assess the capacity to meet the increased case load, scope and range of specific MHPSS support needs of UAC, including but not exclusively the most severe cases;
- To *identify good practices and possible gaps* in the current Greek legal and policy framework as well as in the response of services to the increased case load and particular MHPSS needs of UAC;
- To *propose a set of recommendations* on how to best address existing gaps including immediate and medium/long term actions in light of the realities of the Greek context.

Methodology

The rapid assessment was carried out by the Institute of Child Health, from May to July 2017 by a 3 person research team (psychiatrist, psychologist and social scientist). The methodology included: an extensive desk review of relevant published documents, a questionnaire-based survey of 34 shelter coordinators, 3 focus group discussions with 17 shelter coordinators, 7 focus group discussions with 46 front line staff, as well as 14 semi-structured interviews with key informants including mental health professionals, government officials and service providers. Initial findings were shared with the government, NGOs and IOs through several validation meetings. Limitations of the rapid assessment included the short time frame for the research, the focus on UAC living in residential care (as opposed to those living in protective custody or other forms of care), and the absence of direct interviews with UAC.

SUMMARY OF KEY FINDINGS

Range, scope and scale of MHPSS issues facing UAC

Increased levels of depression, anxiety disorders and post-traumatic stress among refugee children are well documented in the literature.[3,4,5] UAC in particular are considered to be at high risk for mental health and psychosocial distress due to the conditions leading them to leave their home countries (e.g. conflict, displacement,

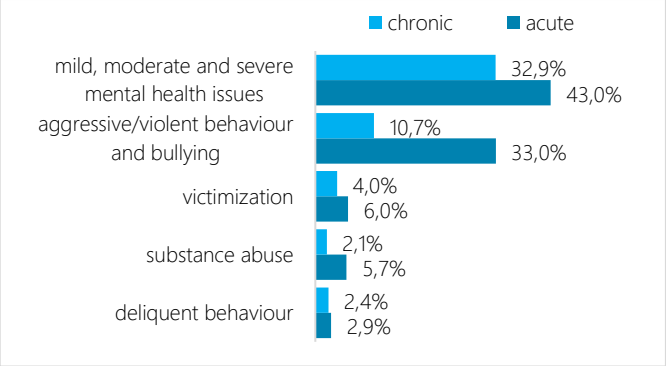
TABLE 1: PREVALENCE OF WORRYING SIGNS NOTICED BY SHELTER STAFF	f (%) of cases (N=1065)*
Having nightmares and/or not being able to sleep	144 (19.7%)
Aggressive behavior against staff	136 (18.6%)
Unusual crying and screaming	83 (11.4%)
Self-harming behavior	81 (11.1%)
Sadness (e.g. not talking, not eating, etc.)	67 (9.2%)
Spending less time with friends	48 (6.6%)
Violence against staff	52 (7.1%)
Violence against other children	57 (7.8%)
Aggressive behavior	47 (6.4%)
Substance abuse (drugs)	42 (5.8%)
Anti-social (isolating themselves)	41 (5.6%)
Substance abuse (alcohol)	38 (5.2%)
Panic attacks and related symptoms	36 (4.9%)
Involvement in illegal activities (vandalism, commercial sexual exploitation)	34 (4.7%)
Disoriented behavior	20 (2.7%)
Suicide attempts	19 (2.6%)
Victim of bullying due to ethnic origin and/or religion	18 (2.5%)
Being a victim of violence by other children	16 (2.2%)
Being a victim of violence by adults	15 (2.1%)
Sexual assault or exploitation by adults	13 (1.8%)
Overt psychotic symptoms (paranoia, etc.)	11 (1.5%)
Victim of bullying due to sexual orientation	8 (1.1%)
Attack on people outside structure (other civilians)	8 (1.1%)
Bullying other children due to sexual orientation	6 (0.8%)
Bullying children due to ethnic origin and/or religion	5 (0.7%)
Sexual assault of other children	5 (0.7%)
Committing crimes	5 (0.7%)
Engaging in high risk sexual behavior	4 (0.5%)
Victim of bullying due to gender	3 (0.4%)
Recruitment of other children in illegal activities	3 (0.4%)

* *More than one signs may concern the same UAC; this is why the total sum of the signs is higher (=1065) than the number of UAC (=730).*

death of family members, persecution, violence including sexual violence, forced recruitment into military or paramilitary groups), the hardships they faced along the journey (e.g. exposure to smugglers and possible violence, exploitation) as well as conditions in their present situation (e.g. extended asylum delays and uncertain future, absence of supportive family network).[6]

The initial questionnaire-based survey of shelter coordinators about the prevalence of MHPSS-related behaviors of UAC in Greece, found that the majority of 'worrying signs' exhibited by UAC related to mild, moderate and severe mental health issues (~75%); almost half related to aggressive, violent behavior and bullying (~44%); while a considerably lower percentage related to delinquent behavior and substance abuse (~5% and 8%, respectively). For all worrying signs, acute incidents outnumbered chronic ones, according to information provided by shelters' coordinators. Shelter personnel reported that many UAC in Greece struggle with stress or anger related to uncertainness or fears about their future, related feelings of hopelessness, as well as loneliness due to separation from family and community. External conditions upon arrival in Greece, also directly or indirectly contributed to increasing the psychosocial

FIGURE 1 % OF REPORTED WORRYING SIGNS BY CATEGORY*



** Cumulative percent exceeds 100% as it was possible more than one worrying sign to refer to the same child*

distress of UAC including: long delays in asylum procedures and a resulting state of limbo due to an uncertain future; contradictory information about asylum procedures, and absence of an individual (e.g. guardian) to advise and provide them with continuous support through their stay in Greece; stress related to co-habitation with up to 30 other UAC in shelters; limited opportunities to exercise autonomy (e.g. absence of pocket money); limited opportunities to access suitable education or vocational training; and in some cases discrimination.

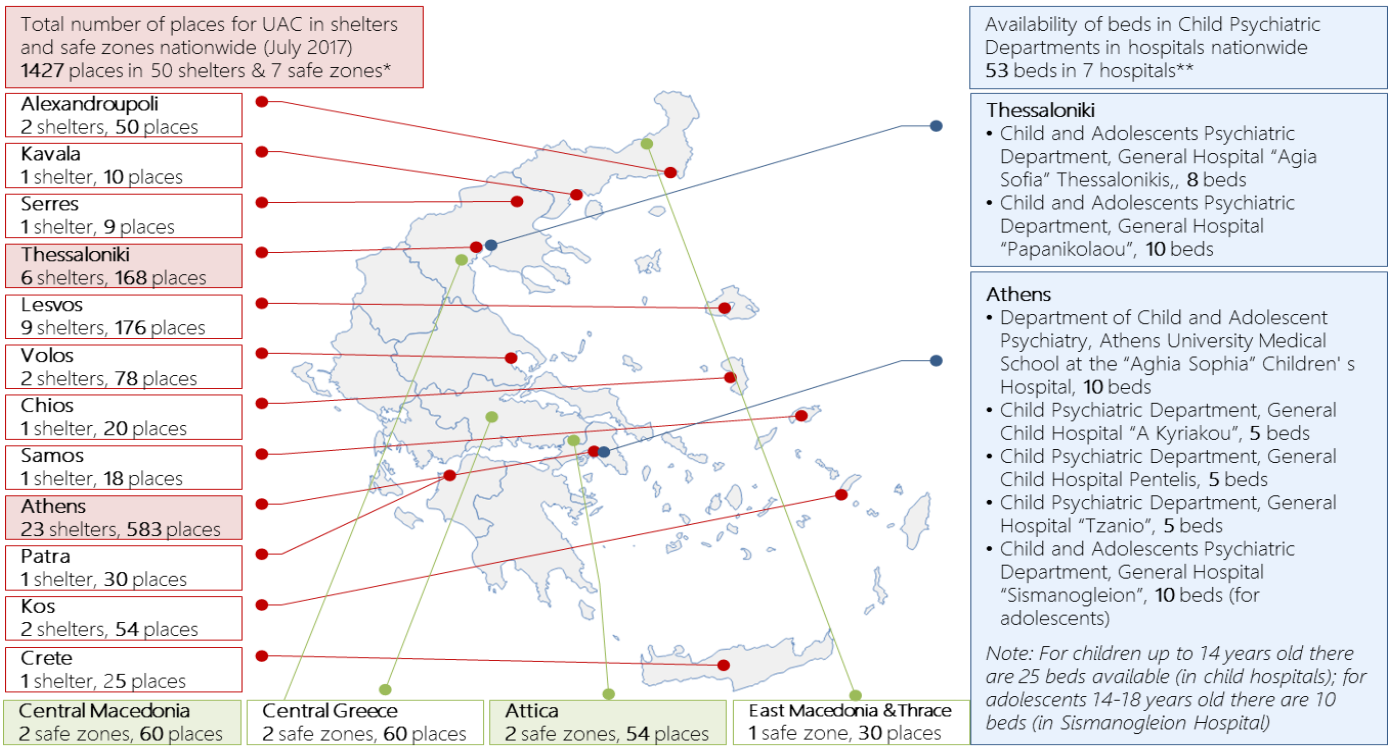
Only a relatively small percentage of UAC displayed signs linked to strictly defined and severe psychiatric disorders such as those requiring medication or hospitalization[7] (e.g. 1.5% reported UAC suffering from overt psychotic symptoms, see Figures 1 and Table 1).

MHPSS Services for UAC in Greece

The primary mode of accommodation and care for UAC in Greece is through medium-sized (20-30 bed) UAC shelters, staffed by multi-disciplinary teams of social workers, caregivers, interpreters, social scientists, lawyers, psychologists, and educators. Front-line psychosocial support is provided by shelter personnel to all UAC accommodated in shelters. For UAC with greater mental health needs, staff may refer them to specialized outpatient mental health care or counseling services operated by NGOs or public institutions.

Shelter personnel reported several challenges in their efforts to support UAC with primary MHPSS needs within the shelter including: lack of adequate information sharing (case file transfer) concerning children's psychosocial and mental health history; challenges related to managing different age groups in the same shelter (including de facto adults who were not properly screened through age assessment procedures); high turnover of staff (making it difficult to establish trust with UAC);

FIGURE 2 AVAILABILITY OF BEDS IN CHILD PSYCHIATRIC UNITS IN PUBLIC HOSPITALS NATIONWIDE



* *Source: EKKA & UNICEF (July 2017) available at: http://www.ekka.org.gr/files/EKKA%20dashboard%205-7-2017.pdf*
** *Source: MoH, Special Committee for the Protection of Rights of People with Mental Disorders (14/5/2013) available at:* http://www.moh.gov.gr/articles/health/domes-kai-draseis-gia-thn-ygeia/c312-psyxikh-ygeia/1398-eidikh-epitroph-elegxoy-prostasias-twn-dikaiwmatwn-twn-atomwn-me-psyxikes-diataraxes?fdl=8836

suitability of staff (need for more defined roles and responsibilities among different professionals in the team); lack of harmonized operational procedures to handle MHPSS problems (currently each shelter develops and applies its own procedures to handle mental health or psychosocial problems of UAC internally with different levels of effectiveness); and the need for more specialised tools/skills and systems within shelters themselves to better equip staff to provide appropriate preventative care.

Coverage of public mental health services

For UAC with more specialized mental health needs, shelter personnel may refer them to pediatric mental health units of public hospitals for clinical assessment and in-patient care.

The assessment found that the majority of mental health services for children and adolescents in Greece (not exclusively for UAC) are concentrated in Athens and Thessaloniki, in the form of specialized in-patient psychiatric units within public hospitals, as well as out-patient counseling facilities. The capacity of these services is limited to 53 beds in child psychiatric hospitals nation-wide. Service providers struggle to meet the needs of Greek children as well as the needs of refugee UAC who may need specialized support, including interpreters. Given the concentration of MHPSS services on the mainland, UAC living in shelters in the Northern Aegean islands, in Crete, and in border areas such as Alexandroupolis have much less access to child-focused mental health services, which are already extremely limited, For example, some locations are serviced remotely by monthly visits from a mental health professional from Athens (see Figure 2). For the over 1,600 UAC on the waiting list for shelter placement who may not be provided with specialized care, access to MHPSS support is even more limited.

The assessment identified a range of challenges in timely referral of UAC requiring more specialized MHPSS support including among others, problems in initiating procedure in virtue of custodianship exercised by public prosecutors; confusion over prosecutors' order for potential involuntary treatment and simple permission to allow for diagnostic and therapeutic services; long waiting lists in public sector child and adolescent mental health services; lack of such services in the Northern Aegean area; relative shortage of available beds in the Child and Adolescent Mental Health Department of public sector hospitals resulting in some adolescents being hospitalized in adult psychiatric hospitals; fragmentation in provided MHPSS and lack of continuity of care including follow-up and collaboration with caregivers; barriers in building relationships between UAC and caregiving or reference persons in the shelters causing more difficulties in managing UAC challenging behaviors.

An additional access barrier may be linked to the limited health literacy of UAC themselves who may have negative stereotypes about mental health needs and potential treatment, mistrust of mental health services or be discouraged by bureaucratic or administrative procedures in accessing MHPSS services.[8]

CONCLUSION

Refugee UAC are at risk of facing greater MHPSS challenges compared to the general population of children. Taking action to improve their access to MHPSS services is thus critical to effectively support them, as well as promote their wellbeing and social integration.[9] The assessment found that the prevalence of severe psychiatric disorders among UAC in Greece was relatively low compared to acute or chronic psychosocial conditions – a finding confirmed by the broader literature on MHPSS. As such, while expanding the availability of specialized services for this smaller group of UAC is critical, greater investment must be made in preventive measures, as well as in early detection and treatment of primary and acute MHPSS symptoms among UAC, in order to avoid the development of chronic MHPSS conditions or clinical disorders.

Within the broader context of their unanticipated stay in Greece, many UAC find themselves in an extended state of limbo due in part to the slow pace of asylum procedures, which can have a detrimental effect on their mental health. The limited capacity to house the increased case load of UAC, combined with limited options for community- and family-based care, limited access to formal education or vocational training, and limited opportunities to exercise autonomy and foster resiliency, can have an accumulative impact on their stress and wellbeing. As such, any effort to expand the delivery of targeted mental health services for UAC, must be delivered as part of a broader comprehensive protection response that addresses their multiple needs, rights in line with their best interests, developmental capacity and wishes.

While beyond the scope of this study, in addition to MHPSS services for UAC, equal attention should be given to providing services to children accompanied by their families who also suffer from increased rates of mental health problems and whose access to appropriate and intensive mental health services is also quite limited and fragmented.

RECOMMENDATIONS

Primary Care

Addressing primary MHPSS challenges among UAC at an early stage is critical to preventing the development of more chronic or severe MHPSS issues among UAC, and is also cost-efficient. Primary prevention should include:

- *Promoting early detection and identification of UAC with mental health and psychosocial issues*: a comprehensive capacity building program for all scientific and care-giving personnel of residential care shelters should be introduced in order to improve the ability of front line workers to identify UAC with MHPSS issues, including those suffering from internalized symptoms, harder to detect
- *Raising awareness of UAC about mental health issues and availability of care*: An awareness raising program to promote mental health literacy among UAC should be developed to provide them with relevant information and skills, and increase the likelihood of their seeking assistance. Separate modules should also be developed on substance abuse and on exploitation and victimization, to be delivered by specialized agencies in an age and culture appropriate manner.
- *Enhancing opportunities for structured learning and social inclusion*: given the psycho-traumatic nature of the relative alienation experienced by UAC in relation the host society[10], all measures promoting their social inclusion may contribute to reducing feelings of anger, frustration, isolation and helplessness, which if unchecked, could evolve into full-fledged mental health conditions. Shelter and Safe Zone providers, and other caregivers working with UAC should take all measures to encourage their access to school and school attendance, vocational or informal education, sports, leisure and other social activities, as well as ensure that they have access to structured daily activities.
- *Expanding the range of options for community based care*: Legal reform to support the development of community-based alternatives to residential care, including foster care, supported independent living and other modalities, should be pursued. It is well-established that institutional residential settings (such as the current shelters) or even more in sites (like in the safe zones) increase rather than decrease psychiatric morbidity. On the contrary applying community-based care through for example foster placement as an alternative to residential care could provide a more supportive setting and a healing experience for UAC which in turn could reduce late onset mental health disorders' occurrence[11].
- *Strengthening relationships of trust between UAC and caregivers*: A comprehensive training scheme for UAC care-giving personnel should be developed in order to promote strengthened relationships of trust between UAC and caregivers – this could focus on dealing with cultural differences, working with traumatized children, and addressing challenging behaviors of adolescents, among other issues. Relatedly, developing operating procedures clarifying the

distinct roles and functions of professionals employed in shelters is of paramount importance. Such operating guidelines could augment current SOPs and could be delivered in comprehensive training schemes to shelter personnel.

- *Addressing key triggers or risk factors of psychopathological manifestations*: as many of the acute or chronic externalizing behaviors are reported to be related to current status events (such as delayed asylum seeking application procedures), improving the overall system of care for UAC could contribute to minimizing their need for MHPSS support. For instance, improving timing of asylum procedures, providing UAC with more information and explanation about the procedures and potential delays, and appointing UAC a legal guardian who can provide individualized and consistent support, guidance, might help to alleviate stress triggers.

Secondary Care

Secondary prevention is of paramount importance for tackling problems once mental health or behavioral challenges arise – and should target all UAC facing MHPSS issues, both acute and chronic cases. Therefore, accessible outpatient, community-based services should be the main focus of efforts to prevent mental health conditions from worsening. Secondary prevention should include:

- *Developing a streamlined and comprehensive system of referrals to hospitals*: often confusion over legal requirements for clinical assessment or provision of clinical services to UAC, especially in cases of involuntary hospitalization, create additional barriers to address mental health issues in a timely and effective manner. A standardization of the procedures could be made in collaboration with the hierarchy of public prosecutors and the government and in turn made known to all operators and agencies involved in UAC's residential care. EKKA, that coordinates the referrals for sheltering of UAC, could lead this effort.
- Providing accessible and appropriate MHPSS to all UAC in need by *establishing specialized community-based mental health services* including in each of the three regions Athens-Thessaloniki-N. Aegean where the majority of shelters are located). The same goal could be achieved by supporting existing specialized services when already operating in order to enhance their capacity to deal with increased needs in provision of MHPSS to UAC.
- Actively involving caregivers in the delivery of treatment schemes including by *institutionalizing procedures to secure close collaboration between the general caregiving "system" and specialized therapeutic services.*
- Addressing gaps in the availability of necessary MHPSS services including geographical inequalities – in particular by *expanding public sector mental health services to underserviced areas* including in the Northern Aegean region – this could benefit UAC as well as the general population which is currently uncovered.

Tertiary Care

Safeguarding continuity of care and enhancing efforts to avoid relapses is also critical for any comprehensive strategy of prevention and support of mental health issues. Tertiary prevention should include:

- *Developing individualized care plans* for UAC with MHPSS issues[12] in collaboration with the caregiving "system" and therapeutic services which, if specialized, could secure continuity and ensure a comprehensive and quality follow up for mid to long term treatment of UAC with MHPSS support needs via specialized community-based mental health services for UAC (i.e. one in each of the three regions with many shelters).
- Establish measures to ensure continuity of care for children who leave care, including cases of UAC coming into adulthood by developing networks between specialized community-based mental health services for children and adolescents and the ones for adult immigrants/refugees to create synergies.

Horizontal Actions

Horizontal actions which cut across all levels of response should include:

- Developing a national information management mechanism for case-based registering and monitoring of UAC in need of MHPSS support[13]
- Promoting participation of UAC (and where possible caretakers of similar ethnic or cultural background) in all levels of decisions concerning them including effective response to MHPSS support needs[14]
- Establishing Standard Operational Procedures for UAC residential care which include protocols for addressing acute of chronic mental health issues of residents
- Clarifying accountabilities of public sector services for the relevant subject matter from top level (Ministries) to first-line service.

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http://www.ich-mhsw.gr/sites/default/files/Report.pdf

[1] More information at: 30.09.2017 Situation Update: UAC in Greece, published by EKKA with support of UNICEF. Available at: http://www.ekka.org.gr/files/EKKA%20dashboard%2030-9-2017.pdf

[2] Mental health and psychosocial support is a term used to describe a wide range of actions that address social, psychological and psychiatric problems that are either pre-existing or emergency-induced (WHO insert source)

[3] Fazel, M., Reed, R. V., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *The Lancet*, *379*(9812), 266-282.,

[4] Lustig, S. L., Kia-Keating, M., Knight, W. G., Geltman, P., Ellis, H., Kinzie, J. D. & Saxe, G. N. (2004). Review of child and adolescent refugee mental health. *Journal of the American Academy of Child & Adolescent Psychiatry*, *43*(1), 24-36.

[5] Bronstein, I., Montgomery, P., & Ott, E. (2013). Emotional and behavioural problems amongst Afghan unaccompanied asylum-seeking children: results from a large-scale cross-sectional study. *European Child & Adolescent Psychiatry*, 1-10.

[6] Mental health and psychosocial problems in emergencies are highly interconnected, yet may be predominantly social or psychological in nature.*C*oncerning *problems of social nature*, these could pre-exist (e.g. child belonging to an ethnic, social, religious or other group that is discriminated against or marginalized; living in poverty), be emergency-induced (family separation; violence, conflict, forced recruitment, destruction of homes and schools, loss of family members, forced displacement, disruption of social networks; vulnerability against victimization as trafficking) or could have occurred due to their current situation (overcrowding and lack of privacy in shelter/camp; not covered by traditional support mechanisms; aid dependency).Concerning *mental health problems*, these could also being pre-existing (e.g. diagnosed mental disorders; depression; substance abuse; self-harming incidents), emergency-induced[6] (e.g. grief; non-pathological distress; alcohol and other substance abuse; depression and anxiety disorders including PTSD) or induced by the current living conditions (anxiety due to living conditions (such as lack of privacy) or due to lack of information about asylum procedures etc.).

[7] These included "persistent mood [affective] disorders" including cyclothymia, dysthymia, and other persistent mood [affective] disorders) or neurotic, stress-related and somatoform disorders (specifically "reaction to severe stress, and adjustment disorders" including acute stress reaction, post-traumatic stress disorder, adjustment disorders and other reactions to severe stress

[8] Majumder, P., O'Reilly, M., Karim, K., & Vostanis, P. (2015). 'This doctor, I not trust him, I'm not safe': The perceptions of mental health and services by unaccompanied refugee adolescents. International journal of social psychiatry, 61(2), 129-136.

[9] UNHCR/UNICEF, (2017), The Way Forward to Strengthened Policies and Practices for Unaccompanied and Separated Children in Europe, p. 25.

[10] Joshi, P. T., & Fayyad, J. A. (2015). Displaced Children. Child and Adolescent Psychiatric Clinics, 24(4), 715-730.

11 Bowlby, J. (1951). Maternal care and mental health. Bulletin of the World Health Organization. Geneva, Switzerland: WHO.
Berens, A. E., & Nelson, C. A. (2015). The science of early adversity: is there a role for large institutions in the care of vulnerable children?. The Lancet, 386(9991), 388-398.
Rutter, M. (1998). Developmental catch-up, and deficit, following adoption after severe global early privation. Journal of Child Psychology & Psychiatry, 39(4):465– 476.

[12] See also related recommendations in Digidiki V & Bhabha J (2017). Emergency Within an Emergency: The Growing Epidemic of Sexual Exploitation and Abuse of Migrant Children in Greece. FXB CENTER FOR HEALTH & HUMAN RIGHTS | HARVARD UNIVERSITY. Available at: https://cdn2.sph.harvard.edu/wp-content/uploads/sites/5/2017/04/Emergency-Within-an-Emergency-FXB.pdf)

[13] Also a key recommendation in UNHCR/UNICEF, (2017), ibid.

[14] Vostanis, P. (2016). New approaches to interventions for refugee children. *World Psychiatry*, *15*(1), 75-77