

# Voice of Ukrainians: Mental health

/ Research among refugees



Sociologický ústav  
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DUŠEVNÍHO ZDRAVÍ

PAQ  
RESEARCH

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# Main findings

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- / 1 / The prevalence of mental illness symptoms among refugees is very high.  
The research used standardized questionnaires PHQ (measuring depressive symptoms such as despondency or fatigue) and GAD (measuring anxiety symptoms such as restlessness and irritability).  
A total of 45% of refugees have problems corresponding to at least moderate depression or anxiety. This is four times more than in the Czech population, where this number hovered around 11% even during the covid crisis.
- / 2 / Less than a third (31%) of people experiencing symptoms of moderate anxiety or depression are aware that it may be a mental illness. Do it more often young people are aware.
- / 3 / Women and young adults under the age of 30 suffer significantly more often from mental problems. Mental health is worsened both by the initial situation of the refugees (poor condition of the house in Ukraine, family in Ukraine) and by the poor socio-economic situation in the Czech Republic (unemployment, poor housing, material deprivation, knowledge of the language and children's participation in education).
- / 4 / In total, according to current estimates, around 75,000 would need professional care adult refugees, but so far only around 5,000 refugees (3%) have used aid in the Czech Republic. 38% considered seeking help. The main barrier to getting help at the moment is the lack of information about what services can be used. Fear and shame about seeking help is also a moderately strong barrier.
- / 5 / A standardized questionnaire measuring the well-being of children showed a reduced quality of life of refugee children (compared to the Czech standard). This is related to the mental health of the adults in the household (which, like the mental health of children, is influenced by socio-economic factors).

# PAQ Research and NUDZ recommendations

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- / 1 / Work on building mental health care capacity for Ukrainian refugees and the Czech Republic and focus on the options available to refugees without knowledge of Czech.
- / 2 / To strengthen and accelerate the possibility of recognition of qualifications in the field of psychiatry and psychology for the creation of the Ukrainian workforce - expansion and acceleration of nostrification capacities, creation of an assistance system for Ukrainian psychiatrists so that they can work with health information systems (reporting to insurance companies, medical facilities, etc.), for example through the assistance of medical interpreters.
- / 3 / Increase refugees' awareness of the symptoms of mental illness and the possibilities of professional care through an educational campaign in Ukrainian, for example through channels of formal communication, such as public administration (for example, KACPU), and social networks most used by Ukrainians (for example, Telegram). Target education also at professionals moving in refugee communities.
- / 4 / Strengthen the recognition of mental illnesses in schools and among general practitioners and paediatricians – i.e. to ensure the training of teachers (e.g. in the form of online training), doctors and other persons in contact with refugees at risk, so that they are able to recognize symptoms in time and know the possibilities of psychosocial care.
- / 5 / Address mental health care not only with regard to traumatic experiences, but also in the context of negative socioeconomic conditions associated with status refugee.
- / 6 / Reduce stressors that, according to research, worsen mental health among refugees - strengthen assistance on the labor market, the offer of free language courses, social support for the most vulnerable groups of refugees, etc.
- / 7 / To work on the destigmatization of mental health in the entire population in order to reduce the barriers to solving problems in a timely manner, both for Czechs and Ukrainians.
- / 8 / Strengthen systemic care for mental health, which is underfunded, including support for prevention and early identification of problems.

# About research

## Objectives and content of the research

In the document, you will find findings from the third representative survey of Ukrainian refugees in the Czech Republic, which dealt with health issues, including mental health and utilization of health care and services. This report describes the incidence of mental health problems refugees in the Czech Republic, the need for professional care and the barriers to achieving it. The report is part of the Voice of Ukrainians research series.

## Implementers and partners

The research is carried out by **PAQ Research, z. ú.** (content and processing of outputs) together with **the National Institute of Mental Health** (cooperation on content and expert input into the report) and **the Institute of Sociology of the Academy of Sciences of the Czech Republic, vvi** (data collection). The research was financially supported by **the RSJ Foundation** and **the Capital City of Prague** (expansion of the sample within Prague).

## Methodology

The report is based on the third wave of research among refugees from Ukraine, in which 1,347 participated refugees from Ukraine. The survey took place from September 5 to September 22, 2022. Analyses of connections with socio-economic conditions are based only on respondents who participated in the first or the second wave of research carried out in June and July (first wave – housing, education) and in August (second wave – work, material situation).

The research is carried out by online questioning of a panel of refugees from Ukraine, which is operated by the Institute of Sociology of the Academy of Sciences of the Czech Republic. The panel was created in cooperation with the Social Security Office of the Czech Republic and the Ministry of Labor and Social Affairs of the Czech Republic, which during the census of the work activity of humanitarian benefit applicants approached refugee households with the opportunity to participate in the research of the Social Security Office of the Czech Republic. Participation in the research is anonymous and paid (transfer of rewards to charity), the identity of the respondents is verified by phone during the recruitment of the panel.

The outputs presented in this report are based on a sample that is **representative in terms of the region of residence within the Czech Republic, the combination of age and gender of the respondents within the regions and in terms of education at the level of the Czech Republic (roughly corresponds to the statistics of the Ministry of Internal Affairs and Communications on beneficiaries humanitarian benefits)**. Representativeness is ensured by a combination of random stratified sampling (approaching randomly selected contacts within the microregions of the Czech Republic) and subsequent data import so that the structure of the sample corresponds to statistics from the data of the Ministry of the Interior of the Czech Republic (CIS) and the Ministry of the Interior of the Czech Republic.

The research represents the attitudes and experiences of people from Ukraine who came to the Czech Republic after February 2022 and are still staying in the Czech Republic.

# Context

War and associated traumatic experiences, but also social and economic stressors are closely related to mental health. Depression and post-traumatic stress disorder (PTSD) are the most commonly detected mental illnesses in the refugee population in the world. <sup>1</sup> Mental illnesses such as PSP, depression and anxiety are burdens that can reduce the ability to function daily and affect the families and communities of those affected.

The mental health of refugees may not be impaired only by the trauma they have experienced. Post-traumatic stress disorder is often associated with experiences directly from the conflict, on the other hand, negative experiences from the daily situation of refugees are more likely to be associated with symptoms of depression.<sup>2</sup> Not only traumatic experiences from the war, but also the status of a refugee and associated with it socioeconomic conditions have a major impact on mental health. <sup>3</sup> Daily recurring stressors strongly influence mental health, and it is therefore important to target intervention programs precisely at them. Unemployment, low income, poor knowledge of the host language and lack of social support worsen the mental health of refugees in the long term, even in the horizon of several years.

<sup>4</sup> At the same time, mental health also affects the socio-economic situation – relationships with family, inability to work or the financial burden of medication. <sup>5</sup> According to the directive for mental health and psychosocial support in emergencies of the United Nations, it is important to create a comprehensive system of care for refugees and their mental health, which does not burden the existing health system. This means that there is a need to build a support system in which people with mental illness are identified in time and motivated to seek specialized care<sup>6</sup>.

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<sup>1</sup> Blackmore et al. (2020). The prevalence of mental illness in refugees and asylum seekers: a systematic review and meta analysis. *PLoS Medicine*, 17(9).

<sup>2</sup> Steel et al. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *PLoS Med*, 302(5), 537-549.

<sup>3</sup> Miller & Rasmussen (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: bridging the divide between trauma-focused and psychosocial frameworks. *Social science & medicine*, 70(1), 7-16.

<sup>4</sup> Bogic et al. (2015). Long-term mental health of war-refugees: a systematic literature review. *BMC international health and human rights*, 15(1), 1-41.

<sup>5</sup> Roberts et al. (2017). Hidden burdens of conflict: Issues of mental health and access to services among internally displaced persons in Ukraine. *International Alert/ GIP-Tbilisi/ London School of Hygiene and Tropical Medicine*.

<sup>6</sup> Inter-Agency Standing Committee. (2007). IASC guidelines on mental health and psychosocial support in emergency settings. *Geneva, Switzerland*.

## **/ 1 / Frequency of mental illness symptoms among refugees in the Czech Republic**

In order to describe the mental health of refugees from Ukraine, we used standardized scales measuring symptoms of depression (PHQ-8) and anxiety (GAD-7). Among the monitored symptoms of depression are, for example, sleep problems, negative self-image, a feeling of hopelessness or fatigue. Among the observed symptoms of anxiety are irritability, nervousness, worry and restlessness. Individually, these symptoms may not mean anything, but their combination indicates mental health problems. Achieving 10 or more points on one of the scales means classification among persons with symptoms of moderate depression or moderate anxiety, and consultation with a psychiatrist is recommended. Only then can he determine the diagnosis.

According to the classification of the diagnostic questionnaire PHQ-8, 42% of adult Ukrainian refugees suffer from symptoms of at least moderate depression (*Chart 1.1*). The symptoms of 14% correspond to severe depression and 7% very severe. In the Czech population last year, 8% of people had symptoms of moderate depression or worse (depression is therefore more than five times more common among refugees).<sup>7</sup> Depression is more common both among refugees and in the Czech population in women (45% suffer from symptoms of moderate depression).

Part of the depressive symptoms described above is typically associated with a reaction to trauma - Recently, there is talk of complex post-traumatic stress disorder, caused by long-term exposure to traumatic events. It can develop precisely in people fleeing war. It is therefore a question whether the measured symptoms can be attributed directly to depressive disorders. At the same time, post-traumatic stress disorder most often appears at the same time as depressive disorder. Mental health and depression associated with trauma must therefore be monitored.

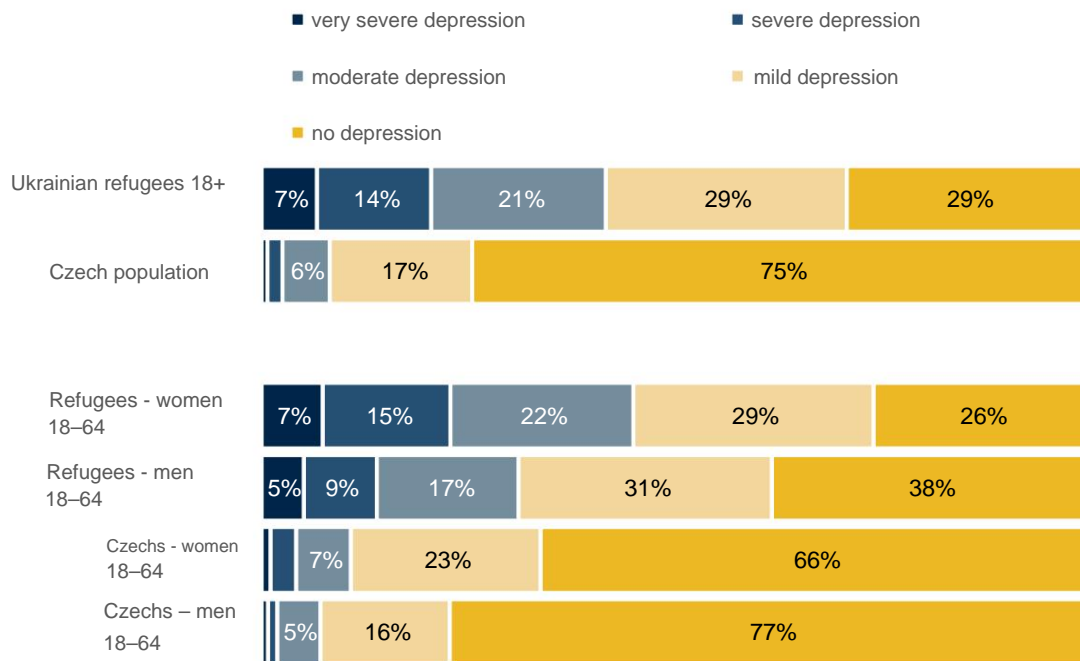
Symptoms of depression and anxiety are measured by standardized questionnaires PHQ-8 and GAD-7. Scores can range between 0 and 25 points. Severity category limits for both types of symptoms are set as 5 (mild), 10 (moderately severe), 15 (severe) and 20 (very severe, in depression). The list of questions of both questionnaires can be found in the [Appendix](#). The result of the questionnaire does not constitute a clinical diagnosis.

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<sup>7</sup> Life during a pandemic, PAQ Research, February 2021



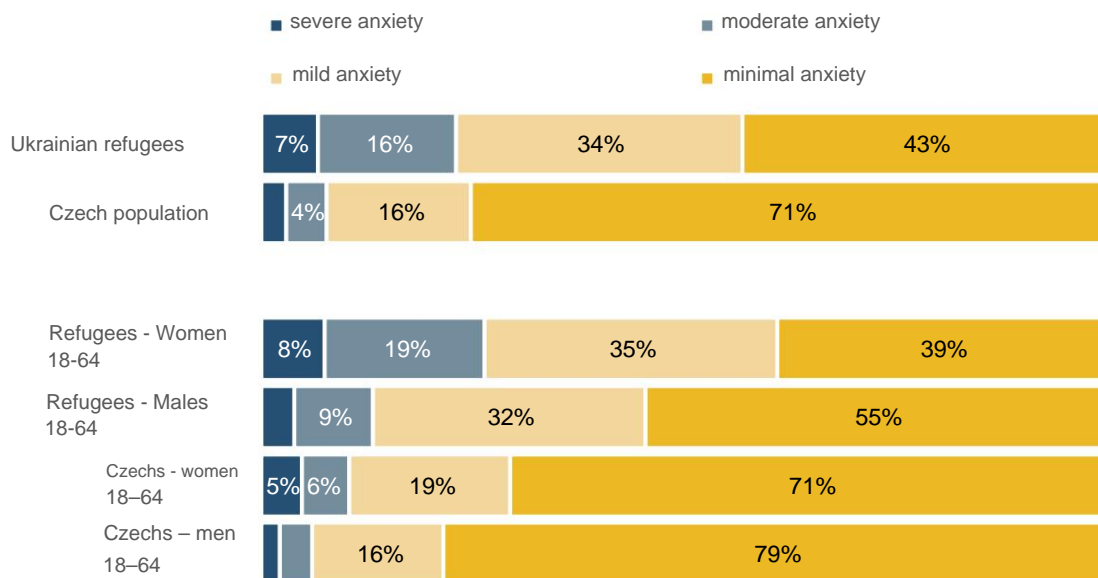
Chart 1.1  
/ Symptoms of depression



Note: N=1231 (Ukrainians), N=2101 (Czechs); PHQ-8; CZ source: Life during the pandemic, PAQ, February 2021

Anxiety symptoms measured by the GAD-7 questionnaire include, among others, nervousness, worry, restlessness, or irritability. The results on the scale of anxiety symptoms are also alarming – 23% of refugees suffer from symptoms of moderate anxiety (compared to 7% among Czechs). Again, anxiety more often affects women (Chart 1.2), who make up over 70% of refugees in the Czech Republic.

Graph 1.2  
/ Symptoms of anxiety disorder

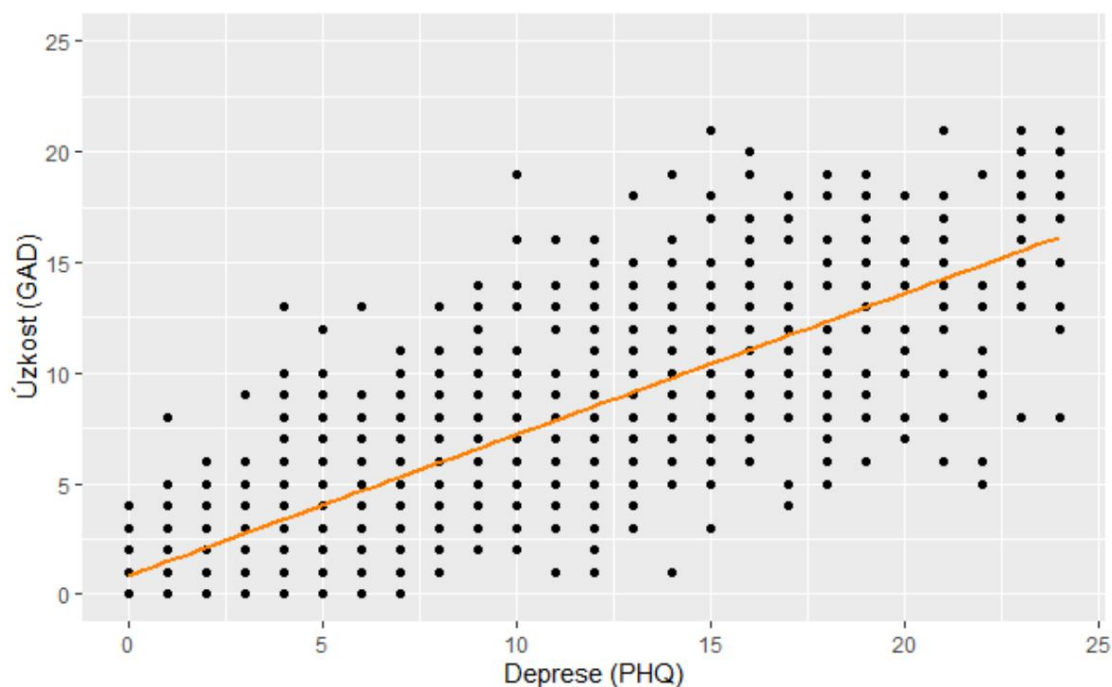


Note: N=1251 (Ukrainians), N=2101 (Czechs); GAD-7, CZ source: Life during the pandemic, PAQ, February 2021

Symptoms of depression and anxiety are closely related in refugees (*Chart 1.3*). In the following analyses, we therefore use a unified indicator to examine the context of mental health problems – whether a person **suffers from at least moderate depression or anxiety**. **A total of 45% of these people are refugees**. This is not very different from the proportion of refugees with symptoms of moderate depression (42%). Only a minimum of people have symptoms of anxiety without suffering from depressive symptoms.

Chart 1.3

/ The relationship between symptoms of depression and anxiety



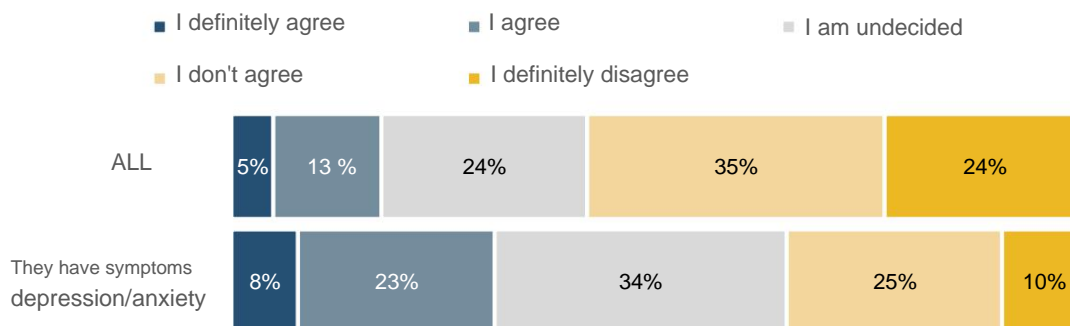
Note: N=1239; Scores on two questionnaires measuring symptoms

In addition to symptoms of mental illness, we also investigated the extent to which refugees are aware of their mental health problems. Perception of one's own mental problems is measured by the Self-I (Self-identification of mental illness scale), which asks about agreement with statements such as *"The current problems I am facing could be the first sign of mental illness"*. Total scores from all five questions can range between 5 and 25, where higher numbers indicate that the respondent admits to the possibility of having a mental illness. People with higher scores tend to be more inclined to seek professional care for their problems.

*Chart 1.4* shows the distribution of responses to one of the items on the Self-i scale, which assesses the extent to which the respondent thinks his or her problems may be a sign of mental illness. The first row shows the responses across the entire population of adult refugees, the second row only the results of those whose symptoms correspond to at least moderate depression or anxiety. The research results show that less than a third (31%) of refugees experiencing symptoms of mental illness believe they may be experiencing mental illness.

Graph 1.4

/ "The current problems I'm facing could be the first sign of mental illness":

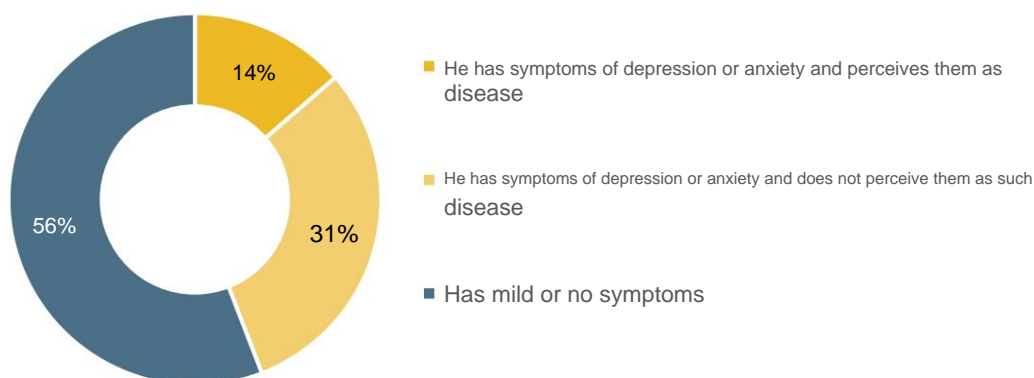


Note: N=1252

In relation to the entire population, 14% of refugees have symptoms of moderate depression or anxiety and are aware of the problems, but 31% have these symptoms and do not admit to possible mental health problems (*Chart 1.5*).

Graph 1.5

/ Total proportion of refugees with symptoms of depression or anxiety



Note: N=1175; results may differ by fractions of a percentage due to missing responses to some question batteries (Self-i) – all mental health questions were optional for respondents.

Based on subjective identification with a mental illness (*Chart 1.4*) and the results of screening questionnaires for depression and anxiety, we estimated the total number of refugees who might need professional care for their problems at the moment. We can also estimate the number of those who perceive their problems as a mental illness and are therefore more likely to seek help themselves. With estimates of 160,000 adult refugees currently residing in the Czech Republic<sup>8</sup>, over 20,000 could use professional care (they have symptoms and admit to a problem), and a total of around 75,000 Ukrainians (have symptoms) would need consultation or help.

The overall self-identification score increases along with the strength of both depressive and anxiety symptoms, confirming that refugees perceive their mental problems. *Chart 1.6* shows

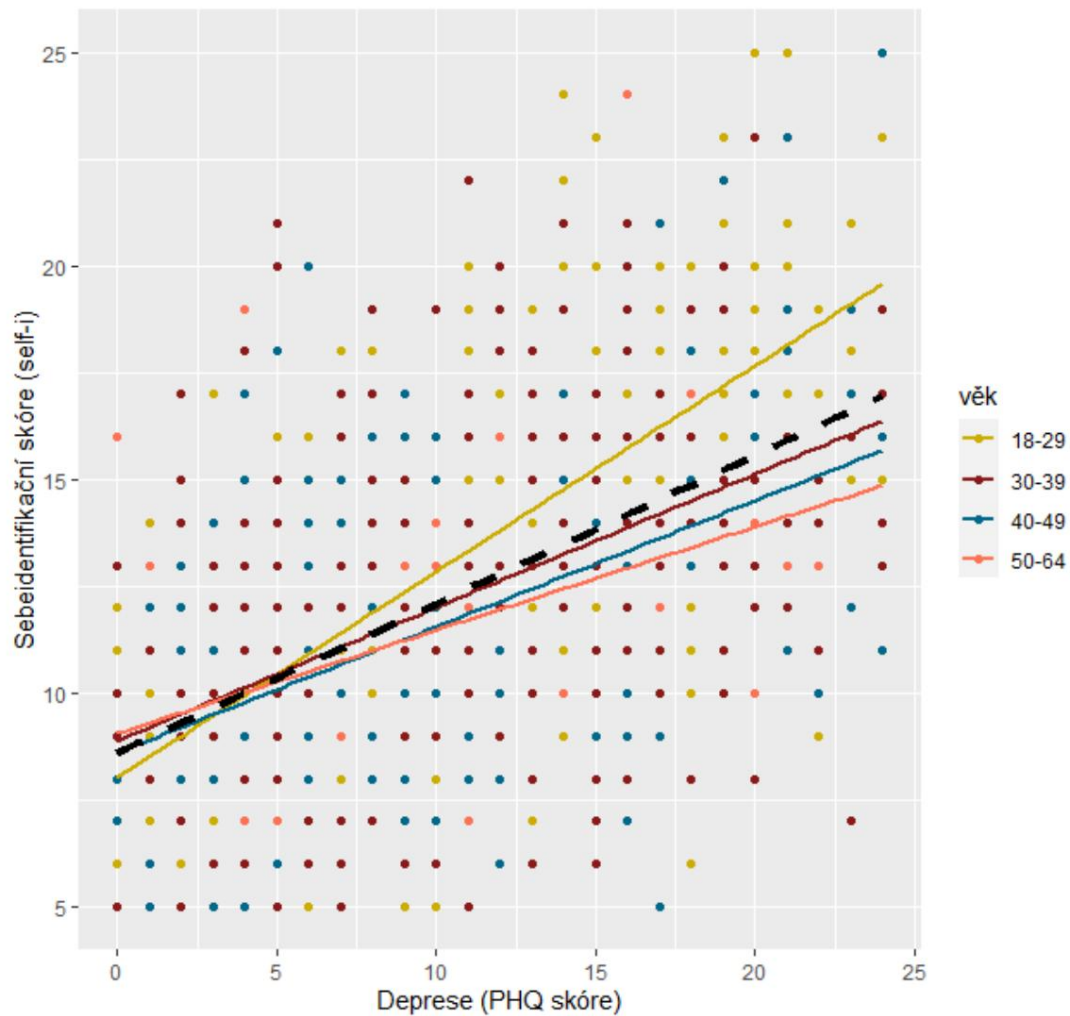
<sup>8</sup> We base our data on school attendance on parents' declarations, actually registered school attendance and the representation of refugee age categories and the demographic composition of refugees (65% are adults 18+).

scores on the Self-i scale in different age groups depending on the degree of depression. A higher slope of the curve means that people with depressive and anxiety symptoms are more likely to admit these problems.

According to the results, young people under 30 are more sensitive to their problems, which is in line with the trend of less stigmatization of mental illness among the younger generation. Of Ukrainians suffering from mental health problems today, it could be the youngest group that is most likely to seek and receive professional care.

Chart 1.6

/ Young people are more sensitive to their own symptoms of mental illness



Note: N=1238. The lines represent the linear regression function, the black dashed line represents the average of all refugees.

The Self-i questionnaire can be found in the Appendix.

## / 2 / Connections with the overall life situation

Among refugees, 45% of adults currently have symptoms of moderate depression or moderate anxiety.

Among the Czechs, this figure was 11 %<sup>9</sup> last year, i.e. four times less.

The prevalence of depression/anxiety symptoms among refugees is higher than among those most at risk groups in the Czech population during the covid-19 epidemic.<sup>10</sup>

Mental health problems naturally affect some groups of refugees more often.

We tested how it is related to the initial conditions with which people from Ukraine came to the Czech Republic (Table 1). Similar to the general population, young people suffer significantly more from depression or anxiety among refugees, mostly those under the age of 30 (59% of them have symptoms of at least moderate depression or anxiety). The mental state of refugees is also influenced by whether some of their relatives remained in Ukraine and whether their house was destroyed in the fighting.

Table 1

/ Prevalence of mental illness symptoms across refugee groups

		Moderate depression or anxiety
All refugees		45%
Sex	Women	49%
	Men	32%
Age	18–29	59%
	30–39	44%
	40–49	36%
	50–64	37%
Their relatives stayed on Ukraine	No relative 1-2	39%
	relatives 3 or more	44%
	relatives	47%
They had relatives in the Czech Republic before the war	Yes	46%
	No	44%
The state of the house in Ukraine	Completely uninhabitable	52%
	It was vandalized but is livable	52%
	He was not hit	41%
Region of previous residence in Ukraine	Area of current fighting	43%
	Formerly occupied area	44%
	Neighborhood of the occupied area	43%
	Other regions of Ukraine	53%

Note: N=1231; % of people whose symptoms correspond to at least moderate depression or anxiety (according to PHQ-8 and GAD-7)

<sup>9</sup> Life during a pandemic, PAQ Research, February 2022

<sup>10</sup> Among Czech women with children or teachers, the rate of depressive and anxiety symptoms rose to 35% at one time.

### / 3 / Context of mental health and living conditions in the Czech

#### Republic

Graph 3.1 shows how different conditions of life in the Czech Republic are related to the occurrence of psychological problems. The material deprivation of the household has a great influence on the psychological state, 51% of refugees in severe material deprivation (according to Eurostat) suffer from at least moderately severe depression or anxiety, compared to 33% in the group of refugees who do not suffer from material deprivation. 11 It is also worse for people who do not have a job (neither in the Czech Republic, nor remotely in Ukraine). Among workers, those who work in a significantly worse qualification than the one they worked in Ukraine suffer from mental health problems more often. Symptoms of anxiety and depression are also more often experienced by people who do not know Czech, specifically, it is decisive if the person in question can communicate in Czech in common situations.

Housing is also related to mental health – people in accommodation facilities (51%) suffer from depression or anxiety more often than those in apartments (42-43%). Finally, the non-participation of children in education<sup>12</sup> – this is again related to the aforementioned types of socio-economic disadvantage (inadequate housing, inability to go to work).

Overall, mental health problems are related to the material situation and quality application in the Czech Republic. The effect of language knowledge may be due to the fact that Ukrainians who do not speak Czech work less often and are more likely to be in unqualified positions.<sup>13</sup> However, language knowledge can also affect the ability to seek help in various situations, feelings of loneliness, etc.

Our results are consistent with larger foreign studies that have identified the main post-migration causes of mental health burden. These include a lack of suitable job offers and a poor material situation, inadequate housing, a language barrier (which has an impact not only on daily life, but also on access to adequate health care) and the processes associated with acquiring a residence permit, which can often be lengthy and discriminatory. Discrimination is another factor that can appear not only in public administration processes, but also from the host population. In the current research, we did not examine discrimination on the part of the Czech public and the state. Finally, according to studies, even feelings of social isolation are a factor in the deterioration of the mental health of refugees.<sup>14,15</sup>

As can be seen, the symptoms of mental illness in refugees are related both to the war situation and the prospect of return, as well as to refugee status and aspects of socio-economic situations such as labor market participation and finances.

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<sup>11</sup> We did not find a relationship between income poverty and mental health, probably because we calculate poverty according to income, which also includes housing provided for free (that is, those who are dependent on allowances and housing from solidarity households are on the same level of workers) - see [previous report from the Voice of Ukrainians series](#).

<sup>12</sup> Data from June, Voice of Ukrainians, PAQ Research

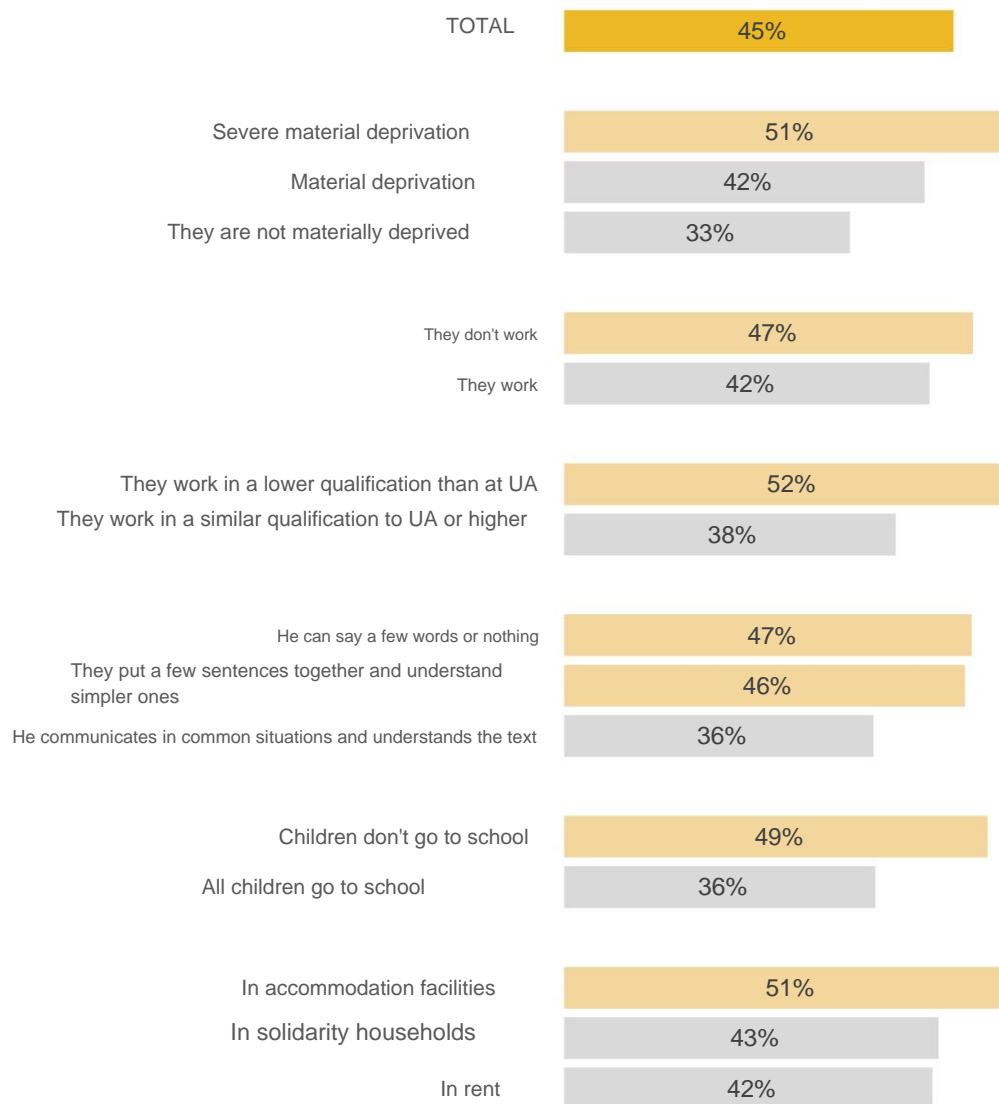
<sup>13</sup> You can find more about the work activity of Ukrainians in the [report from the Voice of Ukrainians series](#)

<sup>14</sup> Hynia (2018). The social determinants of refugee mental health in the post-migration context: A critical review. *The Canadian Journal of Psychiatry*, 63(5), 297-303.

<sup>15</sup> Wu et al. (2021). Time-varying associations of pre-migration and post-migration stressors in refugees' mental health during resettlement: a longitudinal study in Australia. *The Lancet Psychiatry*, 8(1), 36-47.

Graph 3.1

/ Proportion of people with symptoms of at least moderate depression or anxiety according to living conditions in the Czech Republic



Note: N=1240, Percentage of people whose symptoms correspond to moderate depression or anxiety or worse (according to PHQ-8 and GAD-7).

## / 4 / Receiving mental health care

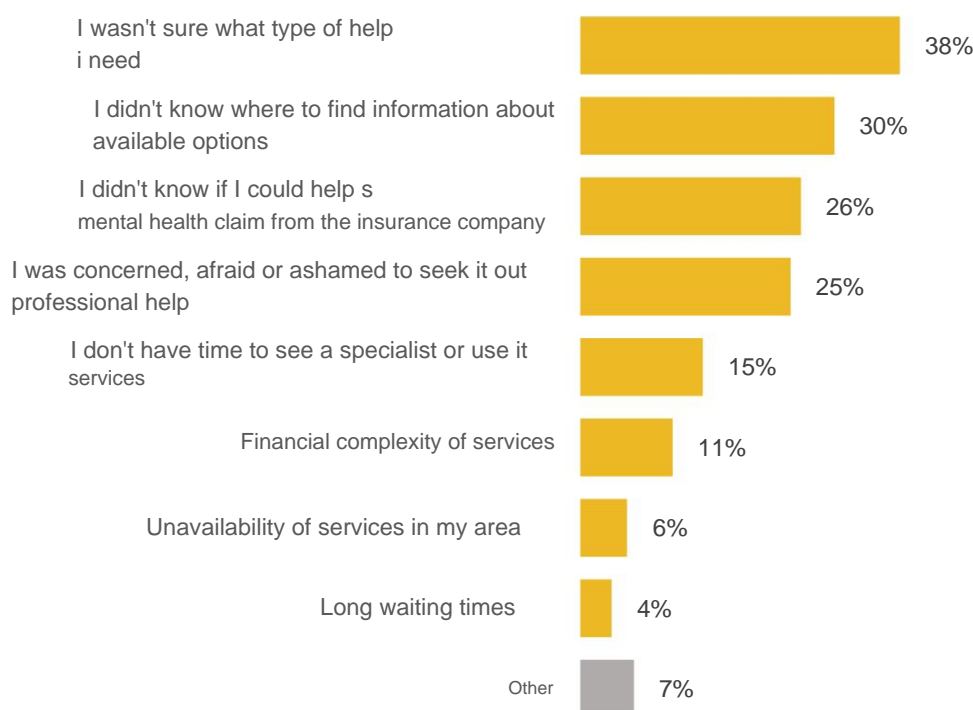
Despite the obvious high incidence of psychological problems among refugees, only a minimum of them in the Czech Republic have so far used professional care (3%). Professional care here includes the services of therapists and doctors (psychiatrist, general practitioner) as well as online and telephone consultations with experts. A number of people coming from Ukraine may have already been at risk of psychological problems before emigrating. However, according to their statements, only a very small part used professional care in Ukraine in the last year before February 2022 (6%). However, 38% of the overall refugee population (and 64% of those with symptoms of at least moderate depression or anxiety) have considered seeking care, so they are aware that professional care could help them.

If care were given to people who have symptoms of depression/anxiety and are considering seeking help, that would be roughly 45,000 adult refugees.<sup>16</sup>

According to the statements of refugees who have used or considered care, the most common barrier is uncertainty about what type of help they actually need (38%). This may be related to insufficient knowledge of mental health issues, but also lack of information about available services, which was cited as a barrier by 30% of people (*Chart 4.1*). A total of two-thirds of refugees considering assistance cited barriers related to lack of information.

Chart 4.1

### / Barriers to the use of mental health care services



Note: N=571; Only people who either considered or directly used psychological help in the Czech Republic; Wording of the question: "When looking for care related to your mental health in the Czech Republic, did you come across any barriers that prevented you from using these services?"

According to foreign studies, in general, access to care for refugees is primarily limited by several factors. These include stigmatization of mental health problems and insufficient

<sup>16</sup> We are based on an estimate of 160,000 adult refugees in the Czech Republic, 45% suffer from symptoms, of which 64% have considered seeking help.



knowledge in this area, barriers associated with refugee status, such as reduced access to health care, but also, for example, the fear of being misunderstood by professionals who have not had the same experiences or do not come from the same cultural background. <sup>17</sup>

In this sense, the results of our research are in line with generally known barriers, but in the Czech Republic the primary barrier to seeking help prevails, i.e. the lack of information about care options. It is possible that access to health care and other existing services is blocked by other problems, such as lack of knowledge of the language and financial inaccessibility, but that the refugees have not yet reached these barriers, as they are not even aware of the possibilities.

## / 5 / Mental health of children

We measured the situation of children in Ukrainian households with the standardized KIDSCREEN-10 questionnaire, which assesses the general quality of life and mental health and is aimed directly at children. In the questionnaire, the adult answers questions about the child, such as whether they have been feeling well or full of energy lately (see [Appendix](#)) and the score can range between 0 and 100, where a value of 100 represents the child's highest quality of life (QoL). The results show that refugee children have a lower score compared to the population of Czech children (8-18 years old). The median score for Ukrainian children is 68, while normative data for Czech children indicate a median of 75. The "satisfied half" of Ukrainian children does not differ from Czech children, but there are more Ukrainian children who, according to their parents, have a worse quality of life. This is reflected in significantly lower QoL values in the 25% of Ukrainian children with the worst parental ratings (see 10th and 25th percentiles, [Table 2](#)).

Table 2

/ Quality of life of refugee children and comparison with the Czech standard (0 = low quality, 100 = high quality)

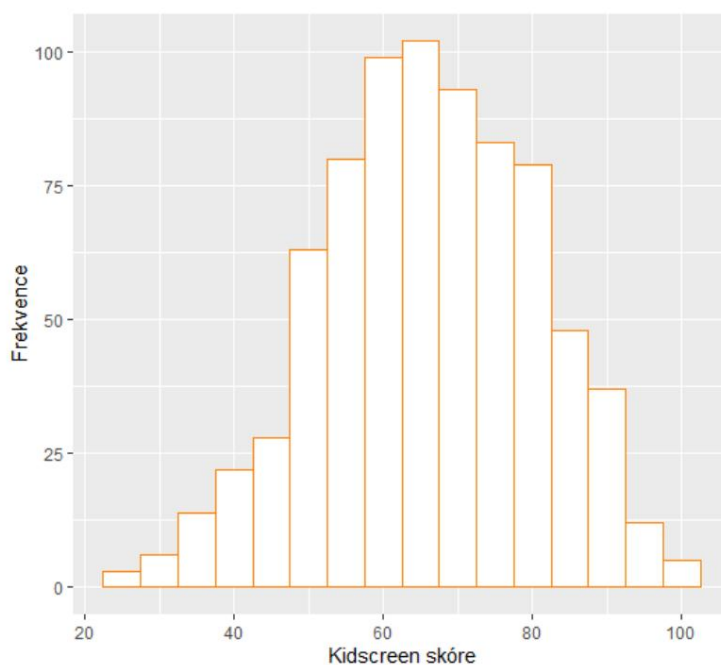
	Ukrainian refugees (quality of life score)	Czech children (quality of life score)
10th percentile	50	60
25th percentile	58	67
50th percentile (median)	68	75
75th percentile	80	82
90th percentile	88	88

Note: N=701 (Ukrainians); Children 5-17, KIDSCREEN-10: parental responsibility version (proxy). Benchmark CZ data: source

<sup>17</sup> Byrow et al. (2020). Perceptions of mental health and perceived barriers to mental health help-seeking among refugees: a systematic review. *Clinical Psychology Review*, 75, 101812.

Graph 5.1

/ Distribution of quality of life scores of children (5–17 years) measured by the Kidscreen questionnaire



Note: N=701 Kidscreen-10; scores converted to 0–100 values. The Kidscreen questionnaire was answered by adult representatives of the household, and a randomly selected child from the household was asked.

The mental state of their family has a relatively strong influence on the quality of life of children (*Chart 5.2*). Children in households where an adult suffers from moderate depression or anxiety have an average QoL score of 63 out of 100, while children with adults with milder problems have an average score of 71 out of 100<sup>18</sup>. This relationship may be because the socioeconomic and other mental health factors described above affect both adults and children in the household. But also the impact of psychological problems of adults on children.

Children's participation in leisure activities, education and inclusion in the collective also has a small effect on the quality of life (data from June) – an increase of three to four points. However, the limited connection may be due to the fact that the data on leisure activities are three months older than the report on mental status and concern the children in the household as a whole. The role of leisure activities cannot be underestimated.

Our results indicate impaired mental health in refugee children, which is consistent with foreign research. They mainly report an increased rate of post-traumatic stress disorder.<sup>19</sup> In dealing with children's psychological health, it is important to focus on early systemic detection of problems. The advantage is that, unlike adult interventions, interventions can be implemented in a school setting, for example by teachers. Interventions should primarily aim at ensuring the basic living conditions of children and integration into the collective.

If necessary, teachers should be able to monitor the mental health of their students and, if necessary, refer them to professional care<sup>20</sup>.

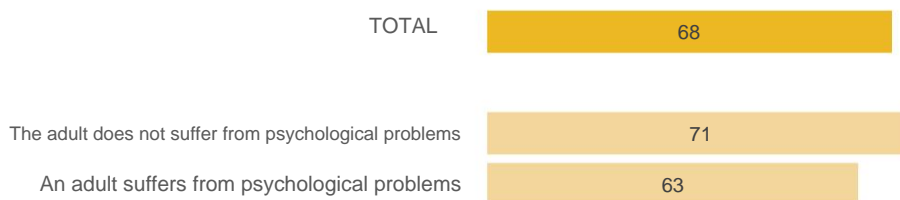
<sup>18</sup> Adults here mean a member of the household who participates in the online survey on behalf of the household, so it does not necessarily have to be the child's parents.

<sup>19</sup> Barenbaum et al. (2004). The psychosocial aspects of children exposed to war: practice and policy initiatives. *Journal of child psychology and psychiatry*, 45(1), 41-62.

<sup>20</sup> Betancourt & Williams (2008). Building an evidence base on mental health interventions for children affected by armed conflict. *Intervention (Amstelveen, Netherlands)*, 6(1), 39.

Graph 5.2

/ Children's quality of life score (0–100) measured by the Kidscreen questionnaire (5–17 years)



Note: N=701. The Kidscreen questionnaire was answered by adult representatives of the household, and a randomly selected child from the household was asked. Mental problems here mean adults with at least moderately severe depression or anxiety (Chart 3.1).

## Contacts for available help for Ukrainians

[www.nudz.cz](http://www.nudz.cz) – The National Institute of Mental Health is currently implementing three projects focused on psychosocial assistance to Ukrainians living in the Czech Republic. You can find more detailed information under the Aid to Ukraine tab, and a map of psychosocial support in the Czech Republic is also available.

[www.samopomi.ch](http://www.samopomi.ch) – page created National Institute of Mental Health in Ukrainian, provides information on mental health and how to care for it with links to available care.

# Appendix

## PHQ-8 (Depression)

How often during the past 14 days have you been bothered by the following problems?

1. Little interest or pleasure in the things you do
2. Feeling down, depressed, hopeless, feeling down
3. Problems with falling asleep, interrupted sleep or, conversely, excessive sleepiness
4. Feeling tired, lack of energy
5. Loss of appetite or, conversely, overeating
6. Feeling bad about yourself or feeling that you have failed or disappointed yourself or your family
7. Trouble concentrating on ordinary things like reading the newspaper or watching TV
8. Visible slowing of movements or speech or, on the contrary, restlessness, restlessness and acceleration movements or speech

Not at all / A few days / More than half the days / Almost every day

## GAD-7 (Anxiety)

How often during the past 14 days have you been bothered by the following problems?

1. Nervousness, anxiety, or feeling on edge
2. Inability to stop worrying or get worry under control
3. Worrying too much about different things
4. Difficulty relaxing
5. So restless that I can hardly sit still
6. I get angry or irritable easily
7. Fear, as if something terrible were about to happen

Not at all / A few days / More than half the days / Almost every day

## Self-I (Identification of mental illness in oneself)

Please indicate to what extent you agree or disagree with the following statements:

1. The current problems I am facing could be the first sign of mental disease.
2. I doubt that I could ever have a mental illness.
3. I might be the type of person who is prone to mental illness.
4. I consider myself a mentally healthy and emotionally balanced person.
5. I am mentally balanced with no mental problems.

Strongly agree / Agree / Undecided / Disagree / Strongly disagree

## Kidscreen (Quality of life for children)

In the last week...

1. Is your child feeling well?
2. Does your child feel full of energy?
3. Does your child feel sad?
4. Does your child feel lonely?
5. Does your child have enough time for himself?

6. Can your child do what they want in their free time?
7. Does your child feel that his parents treat him fairly?
8. Does your child have fun with friends?
9. Is your child doing well at school?
10. Is your child able to pay attention?

**Not at all / A little / Moderately / Very / Extremely**

**Never / Rarely / Quite often / Very often / Always**