Nearing a point of no return?

Mental health of asylum seekers in Croatia

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Introduction

According to the United Nations High Commissioner for Refugees (UNHCR) Global Trends Report - Forced displacement 2017, 68.5 million individuals were forcibly displaced worldwide in 2017 as a result of persecution, conflict, or generalized violence. In other words, the number of new displacements this year has been equivalent to an average of 44,400 people being forced to flee their homes every day.
The 1951 Refugee Convention defines the term refugee as any person who is outside the country of his nationality and owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.
On the other hand, there is no universal definition of the term migrant. The United Nations, for instance, consider the migrant as "a person who resides in a foreign country longer than one year, regardless of reasons or means of migration" (Lalić, Novak and Kraljević, 2014). This distinction leads us to the conclusion that the term migrant encompasses the term refugee.
The Act on International and Temporary Protection (art. 4, para. 5) of the Republic of Croatia defines an asylum seeker as "a third-country national or stateless person who expresses the intention to apply for international protection up until the final decision on the application". This study will focus mainly on asylum seekers residing in the Republic of Croatia from 15 November to 21 December 2018.

European Union's Dublin III Regulation

In recent years, we have witnessed the most massive form of migration since World War II, which is why Europe declared the so-called "migration crisis" in 2015. Migrants and refugees all over the world risk their lives every day in desperate attempts to secure a safer and better life for themselves. In the meantime, the constant pressure on national asylum systems in various European countries has shifted the attention of the public and European Union's (EU) heads of states towards the need for development of a common EU asylum framework. The Dublin III Regulation entered into force in January 2014 and it defines the criteria and mechanisms of determining which EU member state is responsible for processing an application for international protection submitted in one of the member states by a third country national or a stateless person. Under this Regulation, only one European country should be considered responsible for processing the application for international protection of an asylum seeker. This was decided in order to prevent cases of asylum seekers "buying asylum" by moving from one country to another, submitting multiple applications for international protection; or to prevent cases of asylum seekers "orbiting" across Europe, without any member state assuming the responsibility for them (Fratzke, 2015). According to the Dublin III Regulation, the regular procedure is to send asylum seeker back to European country where he/she first entered the EU. However, in practice, the system encounters significant challenges all over the European Union for obvious differences between countries in acceptance policies and living standards; there are huge national differences in international protection approvals, social protection rights and access to labour market for asylum seekers (Brekke & Brochmann, 2015). Experts express concern about the fact that Dublin procedure leads to the delay in international protection request assessment. Such delays may expose vulnerable individuals to additional, unnecessary risks either by sending them back to member states that do not have the necessary capacities to effectively process their requests; or by separating them from their family members and people who are close to them. So far there have been numerous complaints before national courts for separating spouses or parents from their minor children, when applying the Dublin III Regulation. In other cases, individuals with serious health conditions have been exposed to additional risks following the Dublin procedure, because member states have not exchanged enough information on international protection seekers' health care needs while transiting (Fratzke, 2015).

Republic of Croatia in the context of European migration and application of the European Union's Dublin III Regulation

According to the Eurostat data (2017), in 2017, 28 EU member states received 712 235 international protection applications, showing a significant decrease compared to 2015 (1 322 845 requests) and 2016 (1 260 910 requests) when the "refugee crisis" was at its peak. The figures in Croatia follow a similar trend; the number of persons who first requested international protection in Republic of Croatia in 2017 was 975, while in 2016 that number amounted to 2,225. The Republic of Croatia was considered as "transit country" located at the so-called Balkan route that usually begins in Turkey and continues through Bulgaria or Greece, after which migrants move further north, trying to reach destination countries such as Germany or Austria. In September 2015, Hungary closed its borders with Serbia, and in March 2016 North Macedonia, Croatia and Slovenia did the same. Despite this official closure of the so-called "Balkan route", the migration route is still active, combining the "official flow" (asylum seekers who have been transferred to Croatia from Austria and other European countries - mostly Germany, Sweden, Switzerland and Slovenia - under the Dublin III Regulation) and the "unofficial flow" with migrants, in many cases victims of smuggling, crossing to Croatia and further to Slovenia through Serbia or Bosnia and Herzegovina (BiH). The closure of the Croatian border led to a large number of refugees and migrants remaining in the territory of northern Bosnia and Herzegovina for several months in 2018, staying mostly in camps in Velika Kladuša and Bihać. According to the UNHCR Office in Bosnia and Herzegovina (2018), during the period from 1 January to 30 November 2018, 23 132 refugees and migrants were recorded to enter the country, compared to 540 entries recorded in the same period last year. It is estimated that there are currently around 4500-5000 migrants and refugees in the area of Sarajevo and the Una-Sana Canton. Given the sudden influx of a large number of people at the Bosnian-Croatian border area, refugees and migrants have faced a lack of adequate accommodation capacities and/or overcrowded accommodation facilities, poor hygiene conditions, cases of violence, unequal access to health care, lack of psychosocial support and high levels of stress and uncertainty surrounding all the more difficult, costly and dangerous illegal border crossing. As a result, a large number of asylum seekers who arrived to Croatia from Bosnia and Herzegovina in 2018, accommodated at the Asylum Seekers' (AS) Facility in Zagreb, needed additional psychosocial support.

The influx of "Dublin" asylum seekers, transferred from other European Union countries to Croatia, rose in August 2016, and declined slightly in January 2018 (Delescluse, Mujkanović and Silov, 2018). Croatian Ministry of Interior (MUP, 2018) official statistical data show that in the period from 1 January to 30 September 2018, there were 100 incoming transfers made to Croatia, mostly from Austria (46), Germany (21) and Slovenia (14). According to the data of *Médecins du Monde Belgique* (MdM-BE) - Office for Croatia (Delescluse, Mujkanović and Silov, 2018), which provides medical care and mental health support within the Asylum Seekers Facility in Zagreb, a number of patients transferred from Austria, Germany, Netherlands, Slovenia and Switzerland suffering from severe (i.e. cancer and Marfan Syndrome), and chronic diseases (diabetes, cardiovascular disease, etc.), as well as serious mental health conditions (post-traumatic stress disorder (PTSD), psychosis, chronic depression, postpartum depression, etc.) were registered in Croatia.

Mental health of refugees and migrants in the context of the implementation of the Dublin III Regulation

In the past few years, the Dublin III regulation has led to the so-called secondary migration; because of inequalities in living standards, labor market conditions and access to social benefits among EU countries, migrants and refugees often move from the first country in which they sought international protection further "north" (Brekke and Brochmann, 2015). The continuation of movement prolongs the migration phase and with it comes the uncertainty about the future, exposure to the risk of becoming a victim of smuggling or human trafficking, lack of necessary protection and access to medical care.

However, the "official" migration flow according to the Dublin III Regulation, i.e. transfer of persons from countries such as Austria, Germany and Switzerland to the country where they first entered the EU, may have even greater consequences for the mental health of asylum seekers. More specifically, these transfers are usually involuntary, often preceded by arrests and, sometimes, several days spent in detention. In addition, these transfers interrupt the established routines, social networks and established sense of security in the life of an asylum seeker, which is a necessary prerequisite for trauma recovery and successful integration. The most concerning are the transfers during which persons are separated from their families (for instance, a pregnant woman separated from the rest of her family); transfers of persons with severe mental health conditions (psychosis, PTSD, high risk of suicide); persons who had previously applied for international protection and have been waiting for a response for more than two years; persons who had surgeries or other medical interventions already scheduled; and of those who have been transferred from one country to another for the second or third time (Delescluse, Mujkanović and Silov, 2018). For asylum seekers who are exposed to the experiences similar to previous traumatic

events, there is a high risk of retraumatization and exacerbation of the symptoms of depression, anxiety and PTSD. In addition, prolonging the wait for international protection decision, and thus uncertain future, may pose a greater risk for mental health disorders development than the extremely stressful events that asylum seekers were exposed to in their country of origin (Laban, 2010; Silove, 1997).
According to the data provided by MdM-BE (Delescluse, Mujkanović and Silov, 2018), mental health problems of adult asylum seekers transferred from Austria, Germany, Switzerland, Sweden, the Netherlands, Luxembourg, Finland, Slovenia, Belgium and France - who have requested psychological support in the Asylum Seekers Facility in Zagreb in 2017 and 2018 - included symptoms of depressive disorders (insomnia, lack of energy, apathy, concentration difficulties, hopelessness, negative self-image, suicidal thoughts), tension, discomfort, feeling of insecurity, loneliness, anxiety, panic attacks, adjustment disorders, acute stress disorder and symptoms of the post-traumatic stress disorder (PTSD).

Objectives of the Study

The aim of this study was to examine the level of psychological distress, anxiety, depression and post-traumatic symptoms on the entire sample of asylum seekers accommodated at the Asylum Seekers Facility in Zagreb, Croatia. Further aim of the study was to examine the possible differences in the domain of psychological distress, anxiety, depression, post-traumatic symptoms and subjectively assessed quality of life between the population of asylum seekers who arrived in Republic of Croatia under the Dublin III Regulation and of those who arrived to Croatia through non-EU countries. Additional goal was to examine the possibility of predicting the level of asylum seekers' psychological distress based on their satisfaction with various aspects of their lives.

Research questions

1. Determine the level of psychological distress, anxiety, depression and post-traumatic symptoms on a sample of asylum seekers accommodated at the Asylum Seekers Facility in Zagreb, Croatia.
2. Examine the differences in psychological distress, anxiety, depression, post-traumatic symptoms and subjectively assessed quality of life between the population of asylum seekers who arrived in Croatia under the Dublin III Regulation and of asylum seekers who arrived in Croatia through non-EU countries.
3. Examine the possibility of predicting the level of psychological distress based on satisfaction with certain aspects of life on a sample of asylum seekers accommodated at the Asylum Seekers Facility in Zagreb.

Hypothesis

1. Considering the exposure to stressful and traumatic experiences in pre-migration, migration and post-migration phases and the length of the administrative process of waiting for a response to a request for international protection, it is assumed that a large number of asylum seekers will achieve values higher than the cut-off values on the scales of psychological distress, anxiety, depression and post-traumatic symptoms.
2. Given the nature of the transfer under the Dublin III Regulation, which implies a longer administrative response to the request for international protection, as well as the interrupted process of integration in the previous European Union country, and sometimes retraumatization through forced transfer and separation from family members, relatives and people who are close to them; higher results are expected on the scale of psychological distress, anxiety, depression and post-traumatic symptoms, and lower results on the scale of subjective quality of life of asylum seekers transferred to Croatia under the Dublin III Regulation.
3. The assumption is that satisfaction with certain aspects of life, measured by the scale of subjective quality of life, will predict the level of psychological distress of asylum seekers.

Methods

Participants

According to the data of the Ministry of the Interior of the Republic of Croatia (MUP), in December 2018 (during the period of conducting the study) a total of 184 adult persons with asylum seeker status were registered in the Asylum Seekers Facility in Zagreb. Out of that total number, 83 (45.11%) asylum seekers participated in the study. There are several reasons why other asylum seekers did not participate in this study: the majority of asylum seekers were not found in their rooms after several attempts to reach them, some of them refused to participate mostly indicating the resignation and disbelief that their involvement in this study could "make any difference", while a smaller number of asylum seekers did not speak any of the languages for which interpreters were available.

Of those who initially agreed to participate in the study, not a single participant refused to continue the participation during the interview. One participant was eliminated in the course of the interview, as it turned out that he was already granted international protection.

Out of the total number of persons who agreed to participate in the study, 61 were men (73.5%) and 22 were women (26.5%), which corresponds to the total male/female ratio in adult asylum seekers that resided in the Asylum seekers Facility "Porin" in Zagreb at the time of the study (M = 133 (74.3%), Ž = 46 (25.7%).

The average age of participants is **32,2** years, with the youngest participant aged 20 and the oldest 61. The average number of participants' years of education is **11,93**. The highest percentage of participants come from **Iran** (28.9%), then **Syria** (19.3%), **Iraq** (15.7%) and **Afghanistan** (9.6%). Other participants come from Morocco, Algeria, Tunisia, Nigeria, Egypt, Congo, Eritrea and Palestine (*Figure 1*).

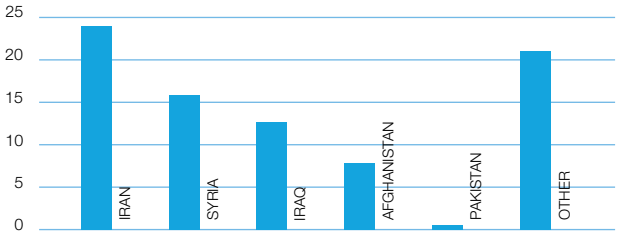

Figure 1. Graphical representation of participants by country of origin.

Out of the total number of study participants, more than half (57.8%) stated they were single, fewer said they were married (37.3%), and the lowest reported percentage of participants were in a relationship (4.8%), while 34.9 % claimed to have children. As many as 69.9% of participants stated that they did not have any relatives/family members in Croatia.

Regarding their current legal status, at the time of the study 53 participants (63.9%) stated they had applied for international protection for the first time and were currently waiting for the decision, 21 participants (25.3%) stated that their first request for international protection had been rejected and they were now waiting for the results of the judicial appeal, 7 participants (8.4%) filed a request for international protection for the second time and were waiting for the final decision, while 2.4% of the participants left this question unanswered (*Figure 2*).

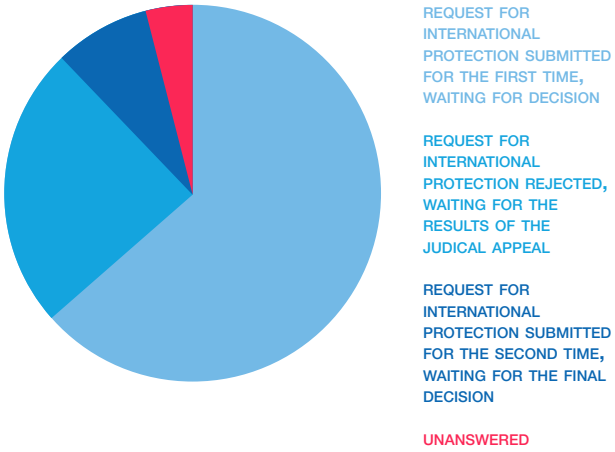

Figure 2. Current legal status of asylum seekers who participated in the study.

The largest number of asylum seekers left their country of origin more than a year ago (66.3%), with 68.7% of the participants living in Croatia for less than 12 months, 16.9% of them living in Croatia between 13 and 24 months, 10.7% living in Croatia between 24 and 36 months, while 1.2% of asylum seekers wait longer than 36 months in Croatia for the asylum process to be resolved.

Out of the total number of participants, 68 (81.9%) stated that they had no mental health problems before coming to Croatia, while 14 (16.9%) stated that they had such difficulties. 24 participants (28.9%) sought support from a mental health professional during their stay in Croatia, while 58 participants (69.9%) did not seek such support.

Most of the participants (78.3%) did not have a work permit during their stay in Croatia, but as high as 92.3% of them stated they would try to find a job if they had a work permit.

Out of the total number of participants, 34 (41%) were transferred to the Republic of Croatia under the Dublin III Regulation. During these transfers, a large number of them were separated from their immediate family **(29.4%)**, and as many as **79.4%** were separated from the persons they consider close (relatives, friends) (*Figure 3*).

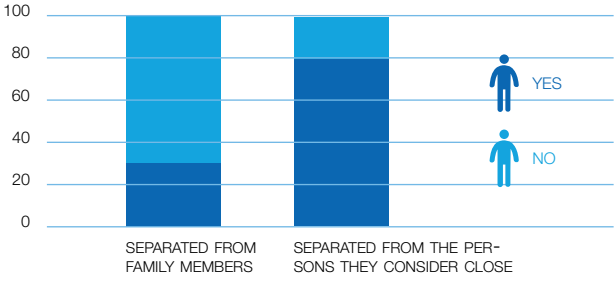

Figure 3. Percentage of participants transferred under dublin III regulation who were separated from their immediate family members and persons they consider close (relatives, friends).

Asylum seekers transferred to the Republic of Croatia under the Dublin III Regulation spent on average about one year in the country they resided in before their transfer to Croatia (M = 15.12, SD = 12.53, Median = 11.50, Mod = 12, Min = 2 Max = 70).

Socio-demographic differences between asylum seekers who were transferred and those who were not transferred under the Dublin III Regulation were tested by χ^2 test for categorical variables and t-test for interval variables (*Table 1*).

The conducted analysis showed differences in countries of origin between those participants who were transferred and those who were not transferred under the Dublin III Regulation; most participants transferred under the Dublin III Regulation come from Syria

and Iraq, while those not transferred under the Dublin III Regulation come from Iran and other countries (χ^2 = 18.10; df = 5; p<0.01).
The conducted analysis also showed differences in the possession of work permits between those who were transferred, and those who were not transferred under the Dublin III Regulation; higher number of participants who were transferred under the Dublin III Regulation had work permits in comparison to those who were not transferred under the Dublin III Regulation (χ^2 = 8.21; df = 1; p<0.01), what is connected to the length of their stay in Croatia.
Similarly, the study showed differences in the time elapsed since the departure from their homeland (χ^2=19.73, df=2, p<0.01); the time of the first request for international protection in the EU (χ^2=49.66, df=2, p<0.01); and the length of their stay in the Republic of Croatia (χ^2=34.61; df=2; p<0.01). Asylum seekers who were transferred under the Dublin III Regulation are away from their homeland for a considerably longer periods of time (*Figure 4*); they had submitted their first request for the international protection in the EU earlier; and stay longer in Croatia compared to those who were not transferred under the Dublin III Regulation.

No statistically significant differences were found between transferred participants and those who were not transferred under the Dublin III Regulation regarding gender, age, marital status and years of education.

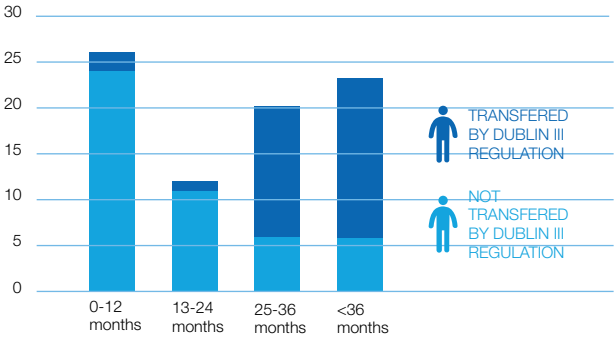

Figure 4. Difference between participants (transferred or not transferred under Dublin III Regulation) considering the number of months since their departure from the country of origin.

VARIABLES	TRANSFERRED TO REPUBLIC OF CROATIA UNDER THE DUBLIN III REGULATION			STATISTICAL SIGNIFICANCE
	NO	YES	TOTAL	
SEX				
Male	35	26	61	χ^2=,26; df=1; p>0,05
Female	14	8	21	
AGE	M=32, 24 SD=8,94	M=32,33 SD=10,28	M=32,28 SD=9,44	t=-0,84; df=80; p>0,05
COUNTRY OF ORIGIN				
Syria	4	12	16	χ^2=18,10; df=5; p<0,01
Afghanistan	4	4	8	
Iraq	5	8	13	
Iran	20	4	24	
Pakistan	1	0	1	
Other	15	6	21	
MARITAL STATUS				
Single	28	20	48	χ^2=0,21; df=2; p>0,05
In a relationship	2	2	4	
Married	19	12	31	
YEARS OF EDUCATION	M=11,55 SD=4,31	M=12,47 SD=3,39	M=11,93 SD=3,96	t=-1,04; df=81; p>0,05
WORK PERMIT				
No	44	21	65	χ^2=8,21; df=1; p<0,01
Yes	5	12	17	

VARIABLES	TRANSFERRED TO REPUBLIC OF CROATIA UNDER THE DUBLIN III REGULATION			STATISTICAL SIGNIFICANCE
	NO	YES	TOTAL	
DEPARTURE FROM HOME				
0-12 months ago	24	2	26	
13-24 months ago	11	1	12	
25-36 months ago	6	14	20	
<36 months ago	6	17	23	
	M=24,77 SD=38,94 Median=12,00 Mod= Min=2 Max=216	M=45,03 SD=28,21 Median=36,50 Mod=36 Min=5 Max=144	M=33,27 SD=36,08 Median=32,00 Mod=36 Min=2 Max=216	χ^2=19,73; df=2; p<0,01
REQUESTED ASYLUM IN THE EU				
0-12 months ago	41	3	44	
13-24 months ago	3	2	5	
25-36 months ago	3	20	23	
<36 months ago	0	9	9	
	M=7,24 SD=7,72 Median=5,00 Mod=1 Min=1 Max=36	M=36,03 SD=19,23 Median=35,50 Mod=36 Min=2 Max=120	M=19,33 SD=19,77 Median=11,00 Mod=36 Min=1 Max=120	χ^2=49,66; df=2; p<0,01
LENGTH OF STAY IN CROATIA				
0-12 months ago	45	12	57	
13-24 months ago	1	13	14	
25-36 months ago	1	8	9	
<36 months ago	0	1	1	
	M=5,02 SD=28,21 Median=4,00 Mod=1 Min=1 Max=30	M=17,03 SD=10,74 Median=18,00 Mod=24 Min=1 Max=46	M=10,06 SD=9,98 Median=5,00 Mod=1,00 Min=1 Max=46	χ^2=34,61; df=2; p<0,01

Table 1 Sociodemographic characteristics and descriptive statistics of participants based on whether or not they were transferred under the Dublin III Regulation; overall results and statistical significance of differences between the two groups.

Instruments

Structured Personal Data Questionnaire

For the purposes of this study, a structured personal data questionnaire was created, collecting data on gender, age, country of origin, marital status, years of education, legal status, work status, migration flow and asylum seekers' traumatic experiences.
At the very end of the questionnaire, the participants were asked two open questions: "*What are the major problems you are dealing with at the moment?"* and "*What helps you the most in your current situation?"*

Personal Well-being Index - PWI (International Wellbeing Group, 2013) is a multidimensional questionnaire designed to measure the subjective quality of life. It contains seven subscales, and on each one the participant can estimate how satisfied he/she is with the standard of living, health, with what they are achieving in life, personal relationships, feeling of safety, feeling of being part of the community and assessed future security. Satisfaction is estimated on 11-degree scale (0 - no satisfaction at all, 10 - completely satisfied), and the score can be calculated for each domain separately or as an average score. Studies show that a scale of 10 possible responses is psychometrically the most appropriate, i.e. it has higher sensitivity and a higher standard deviation, which makes it more useful than scales with fewer possible responses, and is also considered to provide results that best correspond to those found in actual population. Internal consistency coefficient (Cronbach-alpha) found in this study is **α=.805, which is considered a high reliability.**

Hopkins Symptom Checklist-25 (HSCL-25; Parloff, Kelmani Frank, 1954) is a self-assessment instrument for assessing the presence and intensity of symptoms of anxiety and depression over the course of the past week. Answers are given on a scale from 1 to 4 (1 standing for "none" and 4 standing for "extremely"). The questionnaire consists

of 25 items; 10 items describe symptoms of anxiety, and 15 items describe symptoms of depression. Three scores are calculated: the total score is the average score of all 25 items; the total score for the anxiety subscale is the average score of the first 10 items; and the total score of the depression subscale is the average score of the last 15 items. In general, a cut-off value of **≥ 1.75** is being used for all three scores, with an elevated total score being indicative of an emphasized psychological distress without specific diagnosis, and an elevated score on depression subscale being associated with the diagnosis of a major depressive episode (http://hprt-cambridge.org/screening/hopkins-symptom-checklist/). This scale has been used in many studies on migrants' mental health (Mueller, Schmidt, Staeheli and Maier, 2010; Woltin, Sassenberg, Albayrak, 2018) and has proved to be applicable in different languages (Kleijn, Hovens, Rodenburg, 2001; Wind, van der Aa, Knipscheer and de la Rie, 2017). The internal consistency coefficient (Cronbach-alpha) found in this study is α=.882 for the anxiety scale, α=.908 for the depression scale, and α=.935 for the total scale as a measure of psychological distress, which is considered a high reliability.

The PTSD Checklist for DSM-5 (PCL-5, Blevins, Weathers, Litz, Keane, Palmieri, Marx and Schnurr, 2013) consists of 20 items that are equivalent to the symptoms of post-traumatic stress disorder (PTSD) according to the DSM-V manual, and can be used as a screening questionnaire. The first 5 items refer to symptoms of B cluster (re-occurrence of the event), the next two items refer to the C cluster symptoms (constant avoidance of traumatic event stimuli and inability to express emotions), the next 7 items refer to the D cluster symptoms (increased excitability), and the last 5 particles refer to the E clusters symptoms (negative change of opinion). Answers are given on a scale from 0 to 4 (0 means none at all, and 4 means extremely). There are two criteria for determining the indicative results for a possible PTSD diagnosis. The first one is the so-called *cut-off* criteria, according to which all results above a certain value (that value included) are indicative – that is the cut-point score of 33. The second criteria is that each item whose score is ≥ 2 is considered indicative and, according to the DSM-V, the diagnostic criteria is that at least one item from clusters B, C and D and two items from cluster E have a score of ≥ 2. Initial validation of the instrument showed that the questionnaire had strong internal reliability (α =.94), test-retest reliability (r=.82), and convergent (rs=.74 to .85) and discriminatory validity (rs =.31 to. 60). The advantage of this questionnaire is that it is time - efficient and comprehensible to people of different educational levels. The instrument was used in recent studies on refugees' mental health (Acquaye, 2017). Although more psychometric validations of the instrument are needed in order to confirm its applicability in migrant population, the study conducted by Ibrahim et al. (2018) found that the instrument was suitable for use with the Arab and Kurdish populations.

The internal consistency coefficient (Cronbach-alpha) for PTSD Checklist for DSM-5 found in this study is α=.935, what is considered a high reliability and consistent with the findings of the initial validation of the instrument.

All the instruments used were translated in close collaboration between MdM-BE psychologists and Arabic, Persian and French native speakers, specifically for the purposes of conducting this study.

Procedure

The study was conducted at the Asylum Seekers Facility in Zagreb in the period between 15 November and 21 December 2018.

During the research period, asylum seekers were provided with: free accommodation in multi-bed rooms, three meals a day, personal hygiene supplies, clothing and footwear, healthcare including the right to emergency medical assistance and necessary treatment of illness and serious mental disorders, general practitioner's healthcare, monthly gynaecologist and paediatricians visits, support from the mental health professionals (psychologists, psychotherapists, psychiatrists), opportunity to participate in sports and recreational activities organized by non-governmental organizations for children and adults, access to the library and 100 kunas of financial aid (approximately 13 EUR) per month. The conduction of this study was approved by the Ministry of Interior of the Republic of Croatia.

The study was conducted by two psychologists, employees of *Médecins du Monde Belgique, Office for Croatia* - which has been operating at the Asylum Seekers Facility in Zagreb since August 2016 - accompanied by interpreters for Arabic, Persian and French language. A total of five interpreters participated in the study: two interpreters for Arabic, two for Persian and one for French language. All interpreters had previous work experience with the population of asylum seekers.

Asylum seekers learned about the possibility to participate in the study through personal contact with the researcher, accompanied by an interpreter. Psychologists would, along with the interpreter, knock on the bedroom doors of the AS Facility, introduce themselves briefly to the asylum seekers, give an overview of the aim and anticipated duration of the study and emphasize that the study is anonymous and voluntary and that at any time they can stop their participation if they want to. Data was collected for each person separately, and three persons participated in each interview: participant, interpreter and researcher. Prior to joining the study, each participant read and signed informed consent, with explanation of the risks of participating in the study and the possibility of getting professional support if needed. Participants mostly filled out the questionnaire by themselves, except in cases of illiteracy or difficulties in understanding the questions. The average time for completing the questionnaire was 60 minutes.

Results

The data obtained in this study was analyzed statistically using the SPSS 21.0 computer program.

Depression, anxiety and psychological distress

Prior to beginning the data analysis, it was verified whether the results obtained by the study were normally distributed. A Kolmogorov-Smirnov test was used for this purpose. All variables have met the requirements for using the parametric methods for data analysis. In order to determine the differences in the expressed anxiety and depression symptoms, as well as the overall score in self-assessed psychological distress between asylum seekers who were and those who were not transferred under the Dublin III Regulation, we calculated the *t-test*.

VARIABLES	TRANSFERRED TO REPUBLIC OF CROATIA UNDER THE DUBLIN III REGULATION						KOLMOGOROV - SMIRNOV'S TEST	T-TEST
	NO		YES		TOTAL			
	M	SD	M	SD	M	SD		
Anxiety	1,98	0,78	2,04	0,74	2,00	0,76	0,98	t=-0,33 df=81 p>0,05
Depression	2,06	0,70	2,43	0,76	2,21	0,72	0,75	t=-2,28 df=81 p<0,05
Psychological distress total	2,03	0,68	2,27	0,70	2,13	0,70	0,92	t=-1,58 df=81 p>0,05

Table 2 Descriptive statistics for the symptoms of anxiety, depression and psychological distress and statistical significance of differences depending on whether or not the participants were transferred to Republic of Croatia under the Dublin III Regulation (N=83).

There is no statistically significant difference in expression of anxiety symptoms and in total psychological distress score on the HSCL-25 scale between asylum seekers who were, and those who were not transferred to Croatia under the Dublin III Regulation. A statistically significant difference between asylum seekers who were transferred under the Dublin III Regulation and those who were not was found in the expression of depression symptoms (t=-2,28 df=81 p<0,05). According to the arithmetic mean, both groups have an average score above 1.75, which represents the cut-off value, i.e. the result above which the symptoms of anxiety, depression and psychological distress are indicative. In order to determine the number of participants whose result is above this value, we transformed the variable so that the number of persons whose result is above the cut-off value can be distinguished.

Table 3 shows that most asylum seekers, regardless of whether or not they were transferred to Republic of Croatia under the Dublin III Regulation, have considerable symptoms of anxiety **(57.83%)** and depression **(67.47%)** and the overall score **(65.06%)**, i.e. they satisfy the criteria for psychological distress without a specific diagnosis and achieve results associated with the diagnosis of a major depressive episode.

According to the percentages, asylum seekers who have been transferred under the Dublin III Regulation have significantly more severe depression symptoms than those who were not transferred under the Dublin III Regulation, and there is also an observable trend showing higher psychological distress, as well as anxiety symptoms.

	TRANSFERRED TO REPUBLIC OF CROATIA UNDER THE DUBLIN III REGULATION		
VARIABLES	NO	YES	TOTAL
Anxiety			
<1,75	23 (46,93%)	12 (35,29%)	35 (42,17%)
>1,75	26 (53,07%)	22 (64,71%)	48 (57,83%)
Depression			
<1,75	20 (40,82%)	7 (20,59%)	27 (32,53%)
>1,75	29 (59,18%)	27 (79,41%)	56 (67,47%)
Psychological distress total			
<1,75	21 (42,86%)	8 (23,53%)	29 (34,94%)
>1,75	28 (57,14%)	26 (76,47%)	54 (65,06%)

Table 3 Overview of frequencies and percentages of achieved cut-off results for anxiety, depression and psychological distress symptoms of participants, depending on whether or not they were transferred to Republic of Croatia under the Dublin III Regulation, and the overall score (N=83).

Post-Traumatic Stress Disorder (PTSD) Symptoms

Prior to the data analysis, we tested whether the results obtained by the study were normally distributed. For this purpose Kolmogorov-Smirnov's test was used to determine the normality of a distribution. The precondition for using the parametric methods for data analysis was in place. In order to determine the differences in post-traumatic stress disorder symptoms between asylum seekers who were transferred under the Dublin III Regulation and those who were not, we used a t-test.

There is no statistically significant difference in the manifestation of PTSD symptoms between asylum seekers who were transferred under the Dublin III Regulation and those who were not. According to the arithmetic mean, the average result for both groups is above the cut off value of 33, i.e. the result above which the PTSD symptoms are indicative. In order to determine the number of participants whose result is above this value, we transformed the variable so that we could distinguish the number of persons whose result is above the cut-off value.

Table 5 shows that slightly higher number of asylum seekers transferred under the Dublin III Regulation has results above the cut-off value, compared to those not transferred under the Dublin III Regulation; but this difference is not statistically significant. Of the total sample of participants, **50.61**% achieved results above the cut-off value on the PTSD scale.

VARIABLES	TRANSFERRED TO REPUBLIC OF CROATIA UNDER THE DUBLIN III REGULATION		
	NO	YES	TOTAL
PTSD Symptoms			
<33	26 (53,06%)	14 (41,18%)	39 (46,99%)
>33	23 (46,94%)	20 (58,82%)	42 (50,61%)

Table 4 Descriptive statistics for participants' PTSD symptoms and statistical significance of differences between the participants who were and who were not transferred under Dublin III Regulation (N=83).

VARIABLES	TRANSFERRED TO REPUBLIC OF CROATIA UNDER THE DUBLIN III REGULATION						KOLMOGOROV – SMIRNOV'S TEST	T-TEST
	NO		YES		TOTAL			
	M	SD	M	SD	M	SD		
PTSD Symptoms	33,33	18,35	35,29	20,63	34,13	19,22	0,88	t=-0,79 df= ,p>0,05

Table 5 Overview of PTSD symptoms' frequencies and cut off values' percentages for groups of participants depending on whether or not they were transferred under the Dublin III Regulation and the overall result (N=83).

Traumatic experiences of asylum seekers

In order to determine whether asylum seekers differ according to the exposure to traumatic events, as well as the places where they experienced traumatic events, we have calculated a χ^2 test. *Table 6* shows there are no differences in frequencies related to the traumatic events exposure and places where such events occurred between asylum seekers who were transferred under the Dublin III Regulation and those who were not. The difference in frequencies is noticeable only when it comes to exposure to traumatic events in other European Union countries: asylum seekers who were transferred under the Dublin III Regulation experienced greater number of traumatic events in other EU countries than asylum seekers who were not transferred under the Dublin III Regulation (χ^2=11,02; df=1; p<0,01), which is, considering the migration flow of this population, an expected result.

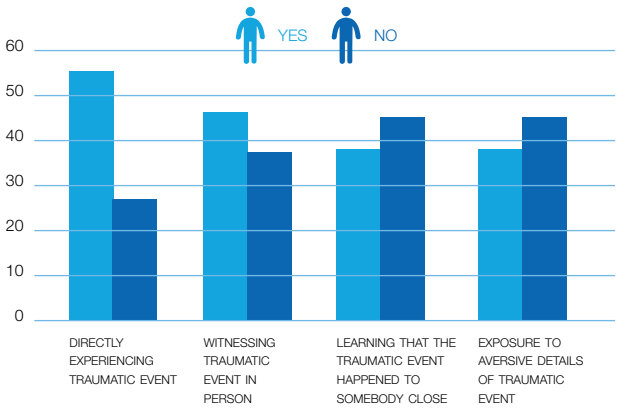

Figure 5. Asylum seekers' exposure to traumatic events (N=83).

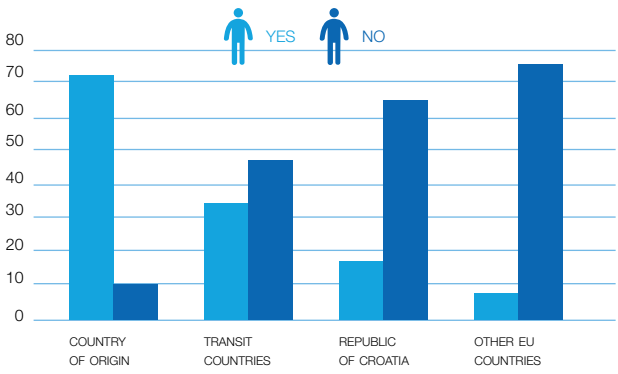

Figure 6. Places where asylum seekers experienced traumatic events (N=83).

VARIABLES	TRANSFERRED TO REPUBLIC OF CROATIA UNDER THE DUBLIN III REGULATION			χ^2 TEST
	NO	YES	TOTAL	
Directly experiencing the traumatic event				
no	16	11	27	χ^2=0,01; df=1; p>0,05
yes	33	23	56	
Witnessing, in person the traumatic event as it occurred to others				
no	25	12	37	χ^2=2,01; df=1; p>0,05
yes	24	22	46	
Learning that the traumatic event(s) occurred to a close family member or a friend				
no	30	16	45	χ^2=2,36; df=1; p>0,05
yes	19	18	38	
Experiencing repeated or extreme exposure to aversive details of the traumatic event				
no	29	16	45	χ^2=1,19; df=1; p>0,05
yes	20	18	38	
Where did it happen?				
Country of origin				
no	7	3	10	χ^2=0,57; df=1; p>0,05
yes	42	31	73	
Transit countries				
no	31	17	48	χ^2=1,45; df=1; p>0,05
yes	18	17	35	
Republic of Croatia				
no	40	26	66	χ^2=0,33; df=1; p>0,05
yes	9	8	17	
Other EU countries				
no	49	27	76	χ^2=11,02; df=1; p<0,01
yes	0	7	7	

Table 6 Frequencies of traumatic events and places where they occurred according to whether or not the participants were transferred under the Dublin III Regulation, the overall result and statistical significance of differences (N=83).

Quality of life

Prior to the data analysis, it was checked whether the results obtained by the study were normally distributed. For this purpose, the Kolmogorov-Smirnov's test for determining the normality of distribution was used. Certain variables met the criteria for using the parametric methods for data analysis, and for those that did not meet such criteria the appropriate nonparametric methods were used. *Table 7* shows descriptive statistics for variables in the study, i.e. for certain aspects of life satisfaction, and overall results.

In order to determine the differences in certain aspects of life satisfaction and in the overall life satisfaction between asylum seekers who were transferred under the Dublin III Regulation and those who were not, we used the t-test and the Man-Whitney test.

Table 8 shows that statistically significant differences have been identified between asylum seekers who were and those who were not transferred under the Dublin III Regulation in the domain of future security (*t*=-3,53; p<0,01) and in the subjectively assessed quality of life in total (t=2,29;p<0,05). Asylum seekers who were transferred under the Dublin III Regulation show statistically lower satisfaction levels with the assessed future security and their overall quality of life in comparison to asylum seekers who were not transferred under the Dublin III Regulation (*ANNEX A*).

ASPECTS OF SATISFACTION WITH:	TRANSFERRED TO REPUBLIC OF CROATIA UNDER THE DUBLIN III REGULATION						KOLMOGOROV - SMIRNOV TEST
	NO		YES		TOTAL		
	M	SD	M	SD	M	SD	
Standard of living	4,43	3,03	3,79	2,69	4,17	2,90	1,00
Health	7,20	3,08	6,29	3,33	6,83	3,20	1,67**
Achievements in life	4,69	2,87	3,76	3,58	4,31	3,19	0,94
Personal relationships	7,10	2,77	7,41	2,89	7,23	2,84	1,68**
Feeling of safety	7,49	2,64	6,53	3,51	7,10	3,06	1,73**
Feeling part of the community	6,49	3,32	5,29	3,73	6,00	3,52	1,38*
Future security	6,94	3,31	3,53	3,92	5,54	3,93	1,58*
Total	63,35	20,50	52,31	22,93	58,83	22,08	0,7

Table 7 Descriptive statistics on aspects of participants' satisfaction with life and their overall life quality depending on whether or not they were transferred under the Dublin III Regulation (N=83).

How satisfaction with different aspects of life contributes to the explanation of asylum seekers' psychological distress

In order to carry out a regression analysis by which we could determine independent predictors that predict the level of psychological distress, we calculated bivariate correlations of predictor variables (life satisfaction aspects measured by the questionnaire assessing the subjective quality of life) with a criteria variable (total psychological distress) based on which we chose three predictors which had the highest correlation coefficients with the psychological distress criteria variable (ANNEX B).

We conducted a regression analysis to determine which aspects of life satisfaction significantly predict psychological distress of asylum seekers. The results point to the conclusion that current satisfaction with their assessed future security, satisfaction with health and satisfaction with what they are achieving in life as a predictor block explains **46,6%** of asylum seekers' psychological distress variance criteria, whereby all three predictor variables have a significant independent contribution in explaining the criteria variable variance. The asylum seekers who are less satisfied with assessed future security, less satisfied with their own health and with what they are achieving in life show a higher level of psychological distress.

PREDICTOR VARIABLES	β	t
Satisfaction with the future security	-.345**	-3,775
Satisfaction with health	-.335**	-3,654
Satisfaction with achievements in life	-.212*	-2,213

$R=.682$ $R^2=.466$ $Ra^2=.446$ $F=22.96$ $p<0.01$

Table 8 Regression analysis results and standardized regression coefficient (β) of psychological distress criteria predictor variables (N=83).

Content analysis of answers to open questions: "What are the major problems you are dealing with at the moment?" and "What helps you the most in your current situation?"

Below are the content analysis results of participants' answers to the question on the major problem(s) they are dealing with at the moment. The question on what they currently consider to be their biggest problems was answered by 78 participants (93.97%). The most common answers were grouped by categories listed in *Table 9*.

CATEGORIES OF ANSWERS	FREQUENCIES	PERCENTAGE
Not having access to work	42	53,85%
Slow administration and waiting for the decision regarding asylum request	36	46,15%
Poor living conditions in the Asylum Seekers Facility	27	35,53%
Health difficulties and obstacles in accessing health care	19	23,68%
Lack of financial means	16	20,51%
Loneliness/separation from family	14	18,42%
Discrimination	9	11,84%

Table 9 Content analysis of most frequent answers to the question "What are the major problems you are dealing with at the moment?"

Some of the answers to the question "What are the major problems you are dealing with at the moment?":

- I have no right to work, and the amount we're getting through financial aid programme is small. I want to work. My child doesn't learn, doesn't go to kindergarten, child care is inadequate.
- Absence of my children and wife, lack of money, stress of waiting for asylum decision.
- Very long process of waiting, lack of basic necessities, unjust allocation of humanitarian aid, noise that children and other people make, they do not ask us how we are and whether we need anything.
- I don't have a job, I'm waiting for a work permit, I don't have access to language courses, bad housing conditions, poor interpersonal relationships, worry and hopelessness, waiting for the asylum, too much time and no structured activities.
- Concern for the family in Iran, uncertainty about getting the asylum, long periods of waiting and uncertainty about family and myself, not being allowed to work.
- My husband has no right to work, we don't have the money for our child, it's cold in the AS Facility. We aren't used to such weather conditions, the child is often ill, and they don't allow food in rooms.
- Waiting has caused me mental health issues. I fled my country because it wasn't safe, and now I have no security either.
- Issues with roommates, they're smoking. Stress, difficulties with sleeping, poor appetite
- I can't sleep for almost two weeks. I'm waiting for too long and can't calm down.
- Worrying for the family I was separated from, they are in danger in Iraq, and we can't be together. Concern about my own mental health, fatigue, medication, lack of patience, feeling of losing control, long periods of waiting without the right to work.
- I just sit and smoke, I don't get out of my room. There are four of us in the room; there is not enough space. Adequate medical care isn't available to me. I would like to teach what I'm good at, just to get out of Porin (AS Facility). Constant stress, struggling to concentrate...
- I was forced to come here; it affects us a lot. The problem is that we need to work. I cannot live just to eat, I have other needs, I have a wife and a daughter. How can I work without knowing the language? There is no formal Croatian language course.
- Waiting for the decision, we have not been given any answer for 2 years
- Awaiting asylum; my future depends on it. Stress for my family who stayed in my country. I've not seen any one of them for 13 years. The loss of my brother who was also a refugee and who drowned, grieving. My mental health deteriorated.
- I'm pregnant and I don't feel comfortable in the hotel room, I'm in poor health, I have problems with increased heart rate due to a negative response. I'm worried about being a single mother.
- Loneliness, I don't feel free, I don't know what will happen in the future, I miss my friends, work, and I have no money.
- When asked what *helps them the most in their current situation, 69 participants answered the question* (80.72%). The most frequent answers were sorted by categories, showed in Table 10.

CATEGORIES OF ANSWERS	FREQUENCIES	PERCENTAGE
Social support friends, family	22	28,94%
Faith prayer, going to church...	16	21,05%
Leisure activities music, books, internet, films...	10	13,15%
Sports	8	10,53%
Mental health professionals	8	10,53%
Helping others/volunteering	6	7,89%
Psychoactive substances alcohol/marijuana	6	7,89%

Table 10 Content analysis of answers to the question "What helps you the most in your current situation?"

Some answers to the question "What helps you the most in your current situation?"

- Sports, talking to other people, other people's company, outdoor walks
- Faith and hope
- Hope to get a positive answer to my asylum request and to be able to support my family
- When I read the Bible, when I pray and go to the church, and when I help people
- Talk with a psychologist
- Prayer, music, internet, Bible, phone conversations with my wife
- Talk with a psychologist, family
- Music, friends, sports, work
- Church, hanging out with my friends and sports
- My family and my relationship with them
- Films, sports, hanging out with friends
- Receiving an answer would be most helpful to me, to finally stop waiting and start living. So far, the marijuana was helping me to calm down.
- Conversations with people I trust
- Volunteering for the Red Cross

Discussion

The aim of this study was to examine the level of psychological distress, anxiety, depression and post-traumatic symptoms on the sample of asylum seekers accommodated at the Asylum Seekers Facility in Zagreb, Croatia. A further aim of the study was to examine the possible differences in the domain of psychological distress, anxiety, depression, post-traumatic symptoms and subjectively assessed quality of life between the population of asylum seekers who arrived in Republic of Croatia under the Dublin III Regulation and of those who arrived to Croatia through non-EU countries (mostly Bosnia and Herzegovina or Serbia). An additional goal was to examine the possibility of predicting the level of asylum seekers' psychological distress based on their satisfaction with various aspects of their lives.

The analysis of the results showed that 57.83% of participants scored above the cut-off result on the anxiety scale; 67.47% of participants scored above the cut-off result on the scale of depression; while 65.06% of the participants scored above the cut-off result on the scale of overall psychological distress (*Table 3*). Similarly, 50.61% of participants scored above the cut-off result on the scale of post-traumatic stress disorder symptoms (*Table 5*).

The results confirm the hypothesis that a large number of asylum seekers will score above the cut-off value on scales of psychological distress, anxiety, depression and post-traumatic symptoms. International studies show that the most frequent mental disorders occurring in the population of refugees and asylum seekers are depression and anxiety, as well as post-traumatic stress disorder (PTSD) (Turini et al., 2017; Fazel, Wheeler and Danesh 2005). A study conducted in Sweden found that 36.1% of asylum seekers had pronounced symptoms of anxiety and depression, 30.1% had post-traumatic stress disorder symptoms, and low subjective well-being was established in 38.3% of participants. A slightly higher number was found in Germany, where 40% of asylum seekers met the criteria for PTSD diagnosis, and almost two-thirds (63.3%) met the criteria for depression diagnosis (BPtK, 2018).

Such results can be interpreted by the exposure of this population to multiple stressful and traumatic experiences in various stages of their migration, as well as by the generally long-lasting and painstaking administrative process of applying for international protection and its uncertain outcome. Each migration represents a process that we can divide into three phases: the pre-migration, migration and post-migration phase. All three phases carry potential risks that can leave long-term consequences to the mental health of refugees and migrants after the migration process is over. In the pre-migration phase, refugees and migrants are often exposed to traumatic and highly stressful experiences such as war, persecution, physical, psychological and/or sexual violence, as well as low economic status and lack of educational and employment opportunities in the country of origin. A study on the mental health of asylum seekers in Serbia found that 96% of the asylum seekers' population was forced to leave their home; 81% of them witnessed murder or death caused by violence; 73% had no access to medical care, and 22% witnessed sexual violence or rape in their country of origin (Vukčević, Dobrić and Purić, 2014). The results of our study show that 67.5% of participants had direct experience of traumatic events such as death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, while 55.4% witnessed such an event in person. 45.8% of them learned that such event had happened to their close one(s), and the same percentage of respondents were repeatedly or intensely exposed to aversive details of such event(s). There were many cases of multiple traumatic experiences, while only 3.62% of participants reported that they were in no way exposed to such traumatic experiences. Regarding the places where the traumatic events occurred, 87.9% of the participants stated that it happened in their country of origin; 41.2% said it was in one of the transit countries, 20.5% said it happened in Croatia, and 8.4% list other EU countries (*Table 6, Figure 5, Figure 6*).

During a migration phase, while moving from the country of origin to the destination country, migrants and refugees can be exposed to a long, exhausting and above all dangerous journey in extreme conditions such as unfavorable weather conditions, exposure to smuggling or trafficking, violence from other migrants, police and military officers or local population in transit countries, lack of basic supplies, separation from or loss of family members as well as the insecurity about the outcome of their journey. Migrants and refugees may be exposed to life threatening situations as they cross the sea in small and unsafe boats, travel in crowded trains and trucks or walk on dangerous routes, without adequate footwear, food and water (Priebe, Giacco and El-Nagib, 2016).

Once residing in the destination country, asylum seekers are faced with new mental health risks. The post-migration environment may have at least as much impact on mental health of refugees and migrants as the pre-migration and migration factors (Porter and Haslam, 2005). In many cases, waiting for the decision on international protection request may take several years, which means that asylum seekers live in a prolonged state of uncertainty. A study carried out on a sample of asylum seekers of Afghan and Iraqi descent in the Netherlands concluded that a long-lasting and uncertain process of acquiring international protection could represent greater risk of developing mental health disorders than adverse life events experienced in the country of origin (Laban, Gernaat, Komproe, Schreuders and De Jong, 2004). Moreover, interviews that civil servants conduct with asylum seekers often involve having to discuss over and over again the reasons for leaving the country of origin and recounting the traumatic experiences, and are often conducted by persons who are not trained to work with people with post-traumatic stress symptoms or disorders. If a person's request for international protection is denied or the right of residence in the country of destination expires, the person is faced with the possibility of detention, and in some cases with deportation to the country of origin.

A large number of asylum seekers in Croatia are unaccompanied. As many as 69.9% of the participants stated that they are alone in Croatia, so we can assume that separation from family members, relatives and friends may result in a lack of social support and feeling of loneliness, but also in concern for the safety of close ones who are left behind in their, often insecure, countries of origin.

For asylum seekers, but also for those who eventually obtain international protection, there are also a series of challenges that hamper their successful integration. These include communication difficulties due to linguistic and cultural differences, the influence of a culture on the manifestation of symptoms and (correct) diagnosis of mental health disorders, differences in family structure and processes affecting the adaptation, acculturation and intergenerational conflicts; exposure to prejudice and discrimination and consequently difficult access to the labor market and integration challenges (Kirmayer et al., 2011).

Unfamiliarity with the administrative procedures of the destination country, lack of information and/or contradictory information from other asylum seekers, but also often from the staff of the humanitarian non-governmental organisations (NGOs) and civil servants involved at asylum seekers' facilities, may represent an additional stressor. The content analysis of the most common responses to the open question "*What are the major problems you are dealing with at the moment?*" (*Table 9*), shows that the largest number of participants in this study (53.85%) stated that being unable to work due to the lack of a work permit as the biggest problem they are currently facing. Other problems mentioned by the participants include a lengthy administrative process and waiting for a response to the international protection request (43.15%), poor living conditions in the asylum seekers' facility (35.53%), health problems and poor access to comprehensive health care (23.68%), lack of financial resources (20.51%), loneliness/separation from their family (18.42%), and discrimination by the local community (11.84%).

Another aim of this study was to examine the differences in psychological distress, anxiety, depression, post-traumatic stress symptoms and subjectively assessed quality of life among the population of asylum seekers who were transferred to the Republic of Croatia under the Dublin III Regulation, and asylum seekers who arrived to Croatia through non-EU countries (mostly Bosnia and Herzegovina and Serbia). Our assumption that asylum seekers who were transferred to the Republic of Croatia under the Dublin III Regulation would achieve higher scores on the scale of psychological distress, anxiety, depression and post-traumatic stress symptoms and a lower score on the scale of subjective quality of life than the asylum seekers who do not reside in Croatia on the grounds of the Dublin III Regulation, was partially confirmed. *Table 2* shows a statistically significant difference in depression symptoms (t = -2.28, df = 81, p<0.05), while *Annex A* shows that there was a statistically significant difference in subjectively estimated quality of life in total (t = 2.29, df = 81, p<0.05), as well as in a subjectively evaluated satisfaction with the sense of one's own future security (t = -3.53, df = 81, p<0.01). Asylum seekers transferred to the Republic of Croatia under the Dublin III Regulation on average demonstrate more pronounced depressive symptoms and lower subjectively assessed quality of life; as well as lower levels of satisfaction with their own sense of future security. The results of other comparable variables follow the foreseen trend, but are not statistically significant. Given the nature of transfers under the Dublin III Regulation, which imply a longer administrative response to the international protection application, as well as the interrupted process of integration in the EU country of destination; as well as retraumatization through forced transfer and separation from family members, relatives and people who are close to them in some cases; these results are not surprising. Out of a total number of participants in this study, 41% of them were transferred to Croatia under Dublin III Regulation. Furthermore, while being transferred, many of them were separated from members of their immediate family (29.4%), and as many as 79.4% of participants were separated from people they considered close (relatives, friends). Differences were also found in the time of departure from their country (χ^2=19.73, df=2, p<0.01), time elapsed from applying for international protection in the EU for the first time (χ^2=49.66; df=2; p<0.01) and the length of their stay in the Republic of Croatia (χ^2=34.61; df=2; p<0.01). Asylum seekers who were transferred under Dublin III Regulation

spend considerably longer periods of time outside of their home country; their request for international protection is in general submitted months or even years earlier than that of asylum seekers that were not transferred to Croatia under Dublin III Regulation; and they are staying in Croatia for considerably longer periods of time then asylum seekers that were not transferred to Croatia under the Dublin III Regulation (*Table 1*). Furthermore, asylum seekers transferred to Croatia under Dublin III Regulation spent on average more than one year in the EU Member State in which they resided before being transferred to the Republic of Croatia (M=15.12, SD=12.53, Median=11.50, Mod=12, Min=2 Max=70). This information confirms the assumption that the transfer has interrupted the process of integration in the first country of reception from which they were unwillingly transferred to another, in most cases unfamiliar country of the European Union. These are often forced transfers that are preceded by arrests, and sometimes by several days spent in detention. An asylum seeker, a person with disabilities who was transferred to Croatia from Austria, originating from Iraq, said: "In September 2016, the police knocked on our door at 6 am and said that we had to go to Vienna with them urgently. We spent two days in Vienna with little food and no medical assistance. The police confiscated our cell phones." (MdM-BE, 201810). Another participant said the following: "They knocked on our door at night, not allowing us to pack our things and change our clothes. In my haste I did not take my medical records and glasses, I took the money I had, some clothes, a cell phone and photos. I stepped out on the road poorly dressed and without my *hijab*. I felt terribly humiliated, and I still often think about that. After that, they took us into custody and then to the airport." In cases of asylum seekers who experience situations similar to previously experienced traumatic events, there is also the possibility of retraumatization, as well as aggravation of symptoms of depression, anxiety, post-traumatic stress disorder and other existing mental health disorders. A large number of asylum seekers transferred under the Dublin Regulation stated they were transferred in the middle of a long and unresolved process of applying for international protection, only to relive the same painstaking process in another country. Furthermore, many of them had already started learning the language of first country of reception, found employment, established social networks and contacts with the local community, as well as formal and informal support systems; their children went to kindergartens and schools (Delescluse, Mujkanović and Silov, 2018). The transfer abruptly interrupts established routines, social networks that were created, and additionally destroys the sense of safety in the asylum seekers' lives, which are all necessary preconditions for recovery from traumatic experiences, as well as for the successful integration.

The last aim of this study was to examine the possibility of predicting the level of psychological distress based on satisfaction with certain aspects of life on a sample of asylum seekers accommodated at the Asylum Seekers' Facility in Zagreb, Croatia. We opted for this concept aware of the fact that psychological distress affects satisfaction with different areas of life, and that satisfaction with different areas of life in return affects the level of psychological distress. Nonetheless, understanding the extremely stressful impact of post-migration factors on mental health of refugees and migrants, as well as the very high level of psychological distress that we consider predominantly situation-conditioned, we decided to examine the impact of satisfaction with different areas of life on psychological distress. By calculating the bivariate correlations of possible predictor variables with the psychological distress criteria variable (*Annex B*), we selected three predictor variables. Regression analysis determined aspects of satisfaction with life that significantly predict psychological distress of asylum seekers. The results of the study suggest that current satisfaction with their sense of future security, satisfaction with health and satisfaction with what they are achieving in life explain, as a predictor block, 46.6% of the asylum seekers' psychological distress variance; whereby all three predictor variables have a significant independent contribution in explaining the criteria variable variance (*Table 8*). The asylum seekers with lower subjectively assessed satisfaction with their sense of future security, lower satisfaction with their own health and lower satisfaction with what they are achieving in life demonstrate a higher level of psychological distress. Some of the major factors that negatively affect mental health of asylum seekers are the insecurity and helplessness that asylum seekers are exposed to in the destination countries. Organization *Doctors without Borders* (2018) emphasizes that, on the basis of in-depth interviews conducted with asylum seekers at the asylum seekers' facility in Sweden, the greatest sources of their stress are fear of the future (29%), long periods of waiting for a decision on the request for international protection (25%) and fear of deportation (23%), which is, in our opinion, closely related to fear of the future as a narrow term.

The predictor variable of satisfaction with one's own health also significantly predicts the psychological distress of asylum seekers. It is common knowledge that stress and traumatic experiences can lead to various psychosomatic symptoms (McFarlane, 2010). Moreover, not only are physical symptoms more perceptible, but asylum seekers themselves are more inclined to seek help from the medical staff by complaining of undefined symptoms such as pain in various parts of the body, digestive problems, insomnia, energy shortage, breathing difficulties, etc. (Delescluse, Mujkanović and Silov, 2018). It is also important to note that numerous studies point to the correlation between traumatic disorders, in particular PTSD, with various health problems such as a weakened immune system, cardiovascular, respiratory, neurological and gastrointestinal problems, pain, susceptibility to infectious diseases and increased risk

of cancer (Schauer and Schauer, 2010; according to Stanković, 2017). One of the participants said: "I spend most of my time waiting in my room thinking about everything that has happened to me and about everything that is still waiting to happen to me. I often feel moderate pain in different parts of the body. I believe that most of this pain is normal and that I have occasionally felt it before, but at the time I also did other things in my life. Now all my attention is focused on my thoughts and my body. I often fear that I will get severely sick if the current situation persists."

The individual contribution of asylum seekers' variable predictor of satisfaction with what they are achieving in life can be linked to often verbalized dissatisfaction with their being unable to obtain a work permit and with the lack of activities for structuring their own time through formal language courses and other educational programs. When people are repeatedly exposed to situations they have no control over, they tend to develop the so-called *learned helplessness*, a state in which they simply give up on trying to change the situation. On an individual level, this can result in depression, as well as in reduced sense of self-efficacy (Rivera, 2016). In addition, research findings show that long-term living in an institutionalized form of accommodation significantly contributes to the feeling of dependency and contributes to demoralization (Von Buchwald, 1994; according to Porter and Haslan, 2005).

In the Republic of Croatia, the right to work for asylum seekers is only granted nine months from the date of submitting an application for international protection upon which the Ministry of Interior has not acted (The Act on International and Temporary Protection, 2018). By consequence, if the Ministry issues a negative decision regarding the asylum request within this timeframe, the asylum seeker does not have the right to work through the entire lengthy process of appealing the decision. At the same time, the monthly financial aid paid to the asylum seeker in the Republic of Croatia is 100 HRK (approximately 13 EUR). This study has concluded that 78.3% of participants do not have the right to work in the Republic of Croatia, and according to the content analysis of the most common responses to the open question "*What are the major problems you are dealing with at the moment?*" (*Table 9*), the highest number of participants (53.85%) stated precisely their being unable to work as one of the biggest problems they are currently facing. Also, 92.3% of those who do not have a right to work said they would try to find a job in Croatia if they were granted a work permit. According to the often quoted intervention pyramid model (IASC, 2007), ensuring the fulfilment of basic physical and psychological needs such as security, adequate accommodation, food, water, access to information, contact with close ones, health care, possibility to spend time in a structured manner and opportunity to contribute through active inclusion and work, will be enough to preserve the mental health of most refugees and migrants. A very small number of them will require the support of mental health professionals if their basic needs are met. Therefore, we can say that further improving the living conditions is one of the fundamental preconditions for improving the mental health and the subjective well-being of asylum seekers.

Conclusion

The study showed that 57.83% of participants scored above the cut-off result on the anxiety scale; 67.47% of participants scored above the cut-off result on the scale of depression; while 65.06% of the participants scored above the cut-off result on the scale of overall psychological distress. Similarly, 50.61% of participants scored above the cut-off result on the scale of post-traumatic stress disorder symptoms.

Asylum seekers transferred to the Republic of Croatia under the Dublin III Regulation on average demonstrate more pronounced depressive symptoms and lower subjectively assessed quality of life; as well as lower levels of satisfaction with their own sense of future security. The results of other comparable variables follow the foreseen trend, but are not statistically significant.

The results of the study suggest that current satisfaction with their sense of future security, satisfaction with health and satisfaction with what they are achieving in life explain, as a predictor block, 46.6% of the asylum seekers' psychological distress variance; whereby, all three predictor variables have a significant independent contribution in explaining the criteria variable variance. The asylum seekers with lower subjectively assessed satisfaction with their sense of future security, lower satisfaction with their own health and lower satisfaction with what they are achieving in life demonstrate a higher level of psychological distress.

Recommendations

- Reviewing the global system, the criteria for selection and the consequences of the transfer under the Dublin III Regulation, bearing in mind the length of stay in the first EU country of reception, and the impact of transfers on the physical and mental health state as well as the well-being of asylum seekers.
- Shortening and unification of the administrative process of international protection decision-making and educating the involved staff on the specificities of working with the population with post-traumatic stress symptoms. Considering the possibility of involving mental health professionals in the international protection seekers' interviewing process.
- Developing a system of clear, continuous and linguistically/culturally adapted provision of information to the asylum seekers about their rights, obligations and available services during their stay in asylum seekers' facilities.
- Granting a work permit for asylum seekers in a notably shorter period of time (after a maximum of three months stay for instance).
- Organizing an official formal Croatian language course available to all interested asylum seekers.
- Providing a regulated full access to primary health care and preventive interventions to asylum seekers in Croatia. Ensuring continuous, quality and comprehensive care of the asylum seekers' mental health through the provision of adequate psychological, psychotherapeutic and specialist support of trained professionals, cultural mediators and translators.

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ANNEX A

	TRANSFERRED TO REPUBLIC OF CROATIA UNDER THE DUBLIN III REGULATION	
ASPECTS	T- TEST / MAN-WHITNEY TEST	LEVEL OF RELEVANCE
Standard of living	0,98	p>0,05
Health	-1,22	p>0,05
Achievements in life	1,31	p>0,05
Personal relationships	-0,75	p>0,05
Feeling of safety	-0,98	p>0,05
Feeling of being part of the community	-1,45	p>0,05
Future security	-3,53	p<0,01
TOTAL	**2,29**	**p<0,05**

Differences between asylum seekers who were not transferred and those that were transferred under the Dublin III Regulation in different aspects of satisfaction with life and in overall satisfaction with life (N=83).

ANNEX B

	Anxiety	Depression	Psychological distress total	PTSD	Life satisfaction total	Satisfaction with standard of living	Health satisfaction	Achievements in life satisfaction	Relationships satisfaction	Feeling of safety satisfaction	Feeling of belonging to the community satisfaction	Future security satisfaction
Anxiety	1	.709**	.892**	.671**	-.502**	-.314**	-.486**	-.350**	-.427**	-.381**	-.120	-.351**
Depression		1	.951**	.798**	-.685**	-.369**	-.494**	-.529**	-.450**	-.400**	-.402**	-.595**
Psychological distress total			1	.805**	-.659**	-.374**	-.529**	-.492**	-.475**	-.423**	-.311**	-.535**
PTSD				1	-.582**	-.365**	-.384**	-.431**	-.432**	-.359**	-.346**	-.458**
Life satisfaction total					1	.561**	.617**	.763**	.608**	.681**	.761**	.747**
Satisfaction with standard of living						1	.326**	.466**	.244*	.214	.204	.298**
Health satisfaction							1	.416**	.269*	.402**	.248*	.307**
Achievements in life satisfaction								1	.414**	.431**	.517**	.410**
Relationships satisfaction									1	.335**	.351**	.359**
Feeling of safety satisfaction										1	.522**	.357**
Feeling of belonging to the community satisfaction											1	.666**
Future security satisfaction												1

Correlation matrix of anxiety, depression, psychological distress and different aspects of satisfaction with life on a total sample of participants (N=83).