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Institution versus family home:

A comparison of community establishment and utilization of mental health services among unaccompanied refugee adolescents placed in small residential care and family homes

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A b s t r a c t

In this study I investigated the community establishment and utilization of mental health services among refugee adolescents who received resident permit in Sweden in 2010. I compared a group of 20 adolescents –boys and girls- mainly from Afghanistan and Somalia, living in small residential care by the Social service management in Stockholm – Socialförvaltningen (SF) - with a group of 10 adolescents from the same countries, living in family homes. The study showed clear differences in adolescents´ adaptation processes. Those who were living in small residential care by SF had a better chance to adapt quickly into their new society compared with the other group. The study showed that refugee adolescents from both groups underutilized mental health services.

Key words: Refugees, adolescents, children, mental health, adaptation.

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Introduction

A refugee refers to a person who is forced to live outside his/her native country because of war or political reasons. An asylum seeking person refers to a person who leaves his country for war or political reasons and seeks protection in another country (Wehmeier, 2000). Unaccompanied asylum seeking children or adolescents refer to those under the age of 18 who come to Sweden without their guardians and seek asylum (Migrationsverket, 2011).The UNHCR report "Protection and assistance to unaccompanied and separated refugee children" uses definition of unaccompanied children or adolescents, also called unaccompanied minors (UAMs), which reads as follow: *"children under 18 years of age who have been separated from both parents and are not being cared for by an adult who, by law or custom, is responsible to do so"* (UNHCR, 2001, p. 3)

This study is an investigation of refugee adolescents who have sought asylum in Sweden. Between 2009 and 2010 Sweden received more than 4,000 unaccompanied children and adolescents. Most of them came from Afghanistan and Somalia (Migrationsverket, 2009). In 2008 there was an increase of Afghan unaccompanied children in Sweden by 117 percent compared with 2007. Totally 46 percent of all Afghan asylum seekers in 2009 were unaccompanied children, and a majority of them belonged to the Hazara ethnic group according to UNHCR´s report. The overall protection rate (who received asylum) for unaccompanied Afghan children in Sweden was 90 percent in 2009 (UNHCR, Sweden, 2010). Afghan children are one of the largest groups of unaccompanied children who have been heading to Europe in recent years and almost all of them applied for refugee status (UNHCR, Switzerland, 2010). UNHCR indicates in its report that Afghan children heading to neighboring countries and to Europe are not doing this just because of war and insecurity. It is also as an efficient economic strategy for afghan families. The families send their children abroad hoping that they can get a job and can contribute to the household of the family that is left in Afghanistan. It seems to be a crucial contribution also to the economy of Afghanistan as a whole. These different reasons for cross-border movements indicate the difficulty to distinguish who is really refugee and who is a voluntary migrant (UNHCR, Stockholm, 2010).

What they tend to have in common is poor experiences of traveling from their country to where they seek asylum. Children who were participating in UNHCR´s report often said that they were abused and exploited throughout their journey to Europe. They reported that they were subjected to both physical and psychological ill-treatment. They were under the constant threat to be deported and were put under stress, fear, and extreme weather conditions. They were also subjected to physical violence and many reported that they saw several of their friends and co-travelers die throughout the journey (UNHCR, Switzerland, 2010).

Marie Hessle reported in her study several reasons why children leave their own country. These reasons are such as being subjected *to "violence out of their ethnicity, religion, political view, gender and sexual preference, torture, arms conflicts, poverty and serious deprivation, medical reasons such as sickness and injuries, not doing military services, trafficking, not having a chance to study, and reunification with the family or relatives".* But she mentions that the reasons these children give while filing for resident permit is mainly three: *"Being subjected to trafficking, fleeing from poverty and family problems and those who have been seeking asylum"* (Hessle, 2009, p. 17).

Countries of refugee children seeking asylum in Sweden

Afghanistan is a country located in South Asia with a population of 31 millions. The country has been involved in war and civil war for decades that marks the country with a huge economic, social, cultural, educational setback. Millions of Afghan people are forced to live in uncertainly and without the basic needs for their everyday life such as food and shelter. Millions of Afghan people also have been forced to leave the country. Afghan children have become a vulnerable group that not just suffers from war, but they also suffer because of malnutrition, ill health, and lack of education. A UNICEF report from 2007 stated that Afghanistan "*had the third highest under age -5 mortality rate worldwide"* (Catani et al., 2009). This situation has forced millions of Afghan people to resettle in neighboring countries such as Iran and Pakistan. The situation for them, particularly for Afghan children who are living in these neighboring countries, is not much better compared with those who are living in Afghanistan.

Somalia is a country located in the horn of Africa with a population of nine millions. The country has been in war and civil war since 1991 and no central government has existed since then. According to a UNICEF report (2007), only 29 percent of the population in the country has access to safe water sources, and less than 30 percent of the children attend primary schools. Children are in particular vulnerable since they face risks both of violence

and exploitation. As a result of the war situation, millions of civilians have been forced to leave their homes and their countries. Many of the children who became apart from their parents have been forced to be used as child labors in neighboring countries that themselves are in war, such as Sudan, Eritrea and Ethiopia. Many of them also have problems when living in other neighboring countries such a South Africa, Kenya and Saudi Arabia, according to UNICEF (2007).

Refugee children / adolescents mental health

Researchers both in Sweden, Finland and Norway have indicated that refugee children have a strong need of psychiatric help, because of being victims of political and military struggles, imprisoned and tortured, forcibly conscripted into military service, sexually assaulted, and resettlement in unfamiliar environments, but also due a long and frustrating migration process when waiting to receive an answer about their asylum application from the Migration Board (Fazel, Wheeler, Danesh, 2005. Billing, 2008 and Vaage et al., 2007). Today there is limited research on refugee children´s utilization of psychiatric services (Vaage & Garlov, Hauff, Thomsen, 2007). However, Mina Fazel and her colleagues (2005) draw the conclusion, based on research on 7,000 refugees resettled in western countries, that 9% of adult refugees resettled in Europe were diagnosed with post-traumatic stress disorder. In the same study she showed that refugee children had a prevalence of post-traumatic stress disorder of 11%. It means that tens of thousands of refugees and former refugees living in western countries have probably been suffering from post-traumatic stress disorder (Fazel, Wheeler, Danesh, 2005).

A number of studies have indicated that unaccompanied minors are particularly vulnerable because of experiencing more threats to mental health and adjustment compared with refugee children living in the host country with their families (McCarthy and Marks, 2010). The risk factors have been identified as traumatic events, PTSD, physical health problem such as TBC-infections, death of relatives and separation from the family, and environmental factors such as poverty, time taken for immigration decisions, isolation and instability, which impact the well-being status of this population.

Asylum seeking procedure and mental health

As Billing in Sweden and Montgomery in Denmark pointed out, the long waiting asylum seeking procedure worsen refugee children´s mental and physical health (Billing, 2008. Montgomery, 2005). Lindencrona found that this was the case also for asylum seeking adults (Lindencrona, 2006). There are studies that indicate that unaccompanied children and adolescents exhibit a stronger overall psychological morbidity compared with children accompanied to the UK by one or more primary caregivers (Michelson and Sclare, 2009). Michelson emphasizes that these unaccompanied children and adolescents may be vulnerable in particular because of experiencing traumatic events and loss of primary attachments. The study also indicated that unaccompanied adolescents tended to miss their scheduled appointment with mental care services. They also attended fewer sessions during treatment compared with accompanied children (Michelson and Sclare, 2009).

The present study

In this study I want to describe the living conditions of refugee adolescents who have come to Sweden without their guardians and are seeking asylum. Residential care is a kind of institution held by Social Services or by private companies. An institution is an establishment with hired professionals and with places for many or just a few children. In Sweden, children are most often placed at institutions – so called HVB-home – mainly for treatment or to investigate their situation. HVB-home (hem för vård eller boende) can be also used to place children for temporary living until a better solution is in hands (Sallnäs 2000).

Institutional care of refugees is common place in Sweden. Sallnäs (2000), however, stressed that the concept of institution care of children is negatively loaded. Many internationally well-known studies during 1950s and 1960s have shown directly harmful effects of institutional care. Hence, whether normal institutional care in Sweden does a good job is still a question. This is a hot issue in Sweden today. The general understanding is that being placed in a family with the warmth of a family environment is generally better than institutional care.

In this study I will examine two questions:

1. Under what living conditions – living in SF-facilities (small residential care units) or in family homes – do unaccompanied refugee adolescents have a better chance to adapt to Swedish society and faster get an introduction into the labor market?

2. To what extend do unaccompanied refugee adolescents with psychological or psychiatric problems utilize the mental health services?

In this study my aim is, by answering to these two above-mentioned questions, to get better knowledge about how unaccompanied refugee adolescents adjust to their situation in Sweden. Which are their living conditions and have they got help by professionals when it comes to psychiatric problems?

Method

Participants

I chose to study unaccompanied refugee adolescents with resident permit in Stockholm. A total of 30 (20 males and 10 females) unaccompanied refugee adolescents, ages 16 to 19 participated in this study. They were between 16 and 19 years old, coming mainly from Afghanistan, Somalia, Eritrea and Iraq. They had been living in Sweden between 1 and 3 years. The common denomination of the participants in both groups was that they came to Sweden without a guardian, they came from counties that have been in war in years, and they received their resident permit shortly after they came to Sweden. I divided these adolescents into two groups: those living in family home placement and those in institutional placement. The first group of 20 adolescents was living in small residential care units by Socialförvaltningen (The Social Service Management), in so called HVB-home (HVB-hem) in Stockholm. They were placed at SF facilities when waiting for a permanent replacement. They were not going through any treatment during their stay at the facilities. The second group of 10 adolescents were living in family homes and were randomly chosen when they visited The Advice Center –Rådgivningsbyrån för ensamkommande barn och ungdomar - at The Social Service Management –Socialförvaltningen / SF- in Stockholm. All interviews at The Advice Center were conducted in Swedish and those adolescents who had major difficulties in communicating in Swedish were dropped from the study. All unaccompanied children who were living in Stockholm were invited to visit The Advice Center two days a week, either by booking a meeting with the social workers working at the center or by dropping in. They could come in and ask any question they wanted. The mission of the center is to provide information to the adolescents in order to get the best help. Most of the participants in the present study were coming from Afghanistan and Somalia. A few of them were from Iraq and Eritrea (see Table 1).

Procedures

The baseline interviews were administrated to the adolescents when they moved into their SF´s facilities in the last part of the year of 2010. At that time they had been living in Sweden between 3 to 6 months and had received permanent resident permit. The baseline interviews were conducted by the author with the help of an interpreter when needed. The second time I interviewed the same 20 adolescents was after six months of their living in the SF´s facilities. This part of the interviews was administrated by the author and the language used for the interviews was Swedish. The participants were informed orally and in writing about the aim of the study and that their answers would be anonymous. They were told that they could at any stage of the study contact me or my supervisor to receive more information and that they could ask to be dropped from the study. All guardians to the children under the age of 18 agreed to that their children who were living in the SF´s facilities would be subjected to some tests and evaluation in order to improve our methods to offer a better living quality to the adolescents. All adolescents received an information sheet to give to their guardians.

Adolescents who visited The Advice Center were also informed both orally and in writing about the aim of this study. They were also told about being anonymous. They were told that they were free to drop out of the study at any time they wished. We did not contact their guardians in order to receive their permission because the children and adolescents who visit The Advice Center did it under our confidentiality. All adolescents living in family homes had received their resident permit within 3 to 6 months and they had been living in their family homes for more than six months.

Design

Baseline interviews with adolescents living in the small residential care units were conducted in the summer of 2010, and sex months later I conducted the second interviews in January and February 2011. The interviews with the adolescents from family homes took place between August and December 2010 and all adolescents who were participating in this study had been living in their family homes for more than six months. Because of implementation restrictions we chose to interview adolescents living in family homes just once. The last interviews were administrated between January and March 2011.

Measures

Structured interviewing was conducted on both groups by using different scales in order to measure the adaptation processes and the adolescents' psychological health. The instruments used were: an adaptation and establishment questionnaire (RBS-questionnaire / appendix I), a depression scale (Montgomery-Åsberg Depression Scale / MADRS, appendix III), a Patient Health Questionnaire for depression (PHQ9 / appendix IV), and The Global Assessment Functioning Scale (GAF / appendix V).

In order to get information about the adolescent´s establishment in the Swedish society, I decided to use a questionnaire – Resultatbaserad styrning /RBS-enkät – designed and used by Socialförvaltningen in Stockholm. I did some adjustment of the questionnaire in order to make it more suitable for this study. By getting information about how the participant were doing in school, being absent more than 20 percent in each semester, receiving homework, doing internship, having a part time job, not having any payment of dept, or paying his/her invoices in time, being charged with a crime, I could measure the adaptation processes of an adolescent in Swedish society.

The depression scale (Montgomery-Åsberg Depression Scale / MADRS, has a response scale ranging from 0 "no symptoms" to 6 "high symptoms" (Appendix III). The items in MADRS are: 1. Mood, 2. Sadness, 3. Anxiety, 4. Sleeping reduction, 5. Loss of appetite, 6. Concentration difficulties, 7. Apathy, 8. Reduced emotional commitment, 9. Depressive thought content, 10. Boredom / suicide thoughts.

The Patient Health Questionnaire for depression (PHQ9 / Appendix IV) measures the psychological statues (depression) in the recent two weeks. The items used in this scale are: 1. Joy, 2. Sadness, 3. Sleeping problems, 4. Tired, 5. Apatite, 6. Poor self-esteem, 7. Concentration difficulties, 8. Overactive or the opposite, 9. Suicide thoughts, 10. Difficulty in managing everyday life.

The semi structured interviews were general questions such as Tell me about your life in your home country… Tell me about your journey to Sweden… and Tell me about your life in Sweden, at the residential care or in the family home. All interviews were administrated by the author and started with sociodemographic questions followed by adaptation questions along with questions about their establishment in the Swedish labor market. These questions were followed by administrating the instruments about the adolescent´s mental health (MADRS, PHQ-9 and GAF), followed by asking some open questions and asking the participant to talk about what she or he wanted to talk about.

The second part of the interview is a semi-structured interview. Here I used just a few questions with fixed response scales, Appendix II. Otherwise I let the participants freely talk about their experiences about their journey on the roads to Sweden, how they were treated in neighboring countries, and about their experiences with the family homes. Some of this information would not have been obtained by just implementing above named questionnaires. The semi-structured interviews gave me new data about adolescents´ different experiences in different stages of their asylum seeking and adaptation processes. Also, in order to know if the participants utilize/underutilize mental health services one first must know if they need to be in contact with those services. In order to find out that, I used some mental health scales which are also presented in table 2. Later I asked them if they had any contact or have any ongoing contact with a child-Adolescents psychiatric center.

Table 1. Sample characteristics

Country, Age, Gender	*16-19 years of age*
Countries of origin / number	Afghanistan / 12 Somalia / 14 Eritrea, Iraq / 4
Gender / number	Females / 10 Males / 20
Length of time in Sweden	1-3 years

Note: 4 adolescents at age of 16, 14 adolescents at age of 17, 8 adolescents at age of 18, 4 adolescents at age of 19.

Table 2. Community establishment framework / Utilization of health services

Criteria	Items
Community establishment	School Work Internship Apartment /rules Insurance Employment Being charged Invoices
Utilization of health services	Montgomery-Åsberg Depression Scale / MADRS Patient Health Questionnaire / PHQ – 9 Global Assessment Functioning scale / GAF Contact with mental health services Having a physical or mental diagnoses Having contact with BUP – Child and Adolescents psychiatric center or an adult psychiatric center

Sample characteristics of the participants are reported in Table 1. Table 2 shows the measures I used in order to find out more about the adolescents' establishment in Swedish society.

Validity

Because of having a small number of participants in this study I am aware of the limitation of external validity in this study. Internal validity, by contrast, can be considered adequate, as I used established instruments with good psychometric properties.

Ethical issues

Permission was obtained from the head of child and adolescents unit at Socialförvaltningen in order to interview adolescents living in residential care. Permission was obtained from the adolescents´ guardians about interviewing the adolescents when they moved into FSs´ residential care. All adolescents received an information sheet about the purpose of the study with the name, phone number and email address of the study instructor and the supervisor. The adolescents were informed both orally and in writing that all information they would give would be processed in such a way that their identity would not be revealed and that they could contact me if they at any time did not want to be part of the study at any time. All social workers who are working at SF have professional secrecy and are not allowed to contact the adolescents´ guardians in order to let them know about the visit or the content of the visit when adolescents come and visit us at The Advisor Center. The participants living in family homes were also informed about the purpose of the study and they received a similar information sheets as the adolescents living in Residential care for more information and farther contact. The adolescents from family homes were encouraged to talk about this study with their guardians and could come back to us in case of having additional questions or dropping from the study.

Methodological considerations

The design of my study of unaccompanied refugee adolescents is a mixed method research design (Jang, et. al., 2008; Teddlie & Tashakkori, 2009; Teddlie & Yu F, 2007) with structured instruments and open questions. The mixed method design has shown to be an effective and usable tool in the field of public health (Pettersson, et. al., 2009). It is

particularly valuable when it comes to a research topic that we need to explore in which we do not have strong hypotheses to start with.

Results

As shown in Figures 1 and 2, a total of 35 percent of adolescents (7 of 20) who were living in SF´s small residential care received planned homework assistance between 1 and 3 hours a week compared with 10 percent of those (1 of 10) who were living in family homes. Ninety percent of adolescents (18 of 20) placed at SF´s facilities had planned leisure activities and received 1500 SEK each year for this purpose, while adolescents living in a family home did not receive any money for this purpose and they (2 of 10) had a rate of 20 percent for planned leisure activities. All adolescents living in SF´s facilities were required to learn swimming and those who wanted could get truck license. All these activities were paid by SF. There were no mentors or volunteers available for those adolescents who were living in FH (Family Homes) while adolescents placed in SF (Socialförvaltningen) engaged in two programs for having a voluntary contact with a mentor and a volunteer. The rate for having a mentor was 25 percent (5 of 20) and for having a volunteer was 90 percent (18 of 20) for SFs´ adolescents. Figures 1 and 2 also present the number of adolescents who engaged in one or two scheduled work training activities during their stay at FH or SF. These rates were 80 percent (16 of 20) and 20 percent (2 of 10), respectively, for SF and FH.

Based on these results it seems as if the adolescents who were living in SF small residential care had a better chance to improve their language skills and manage with their school programs by receiving more help with homework. They also had a better chance to get an introduction into Swedish labor market by getting work training ones or twice in a period of sex months. In addition, they had a better chance to adapt into Swedish society by having contact with both a mentor and a volunteer. A mentor helps them to make themselves familiar with Swedish industry structure and condition. A volunteer helps them to have everyday contact with a Swede. The adolescents also had a better chance to adapt themselves into the society by having planned leisure activities and planned homework activities. Family home adolescents seemingly miss mostly all of above mentioned opportunities.

Figure 1. Adolescents, living in SF´s residential care, who were engaged in different activities to facilitate their adaptation in the Swedish society,

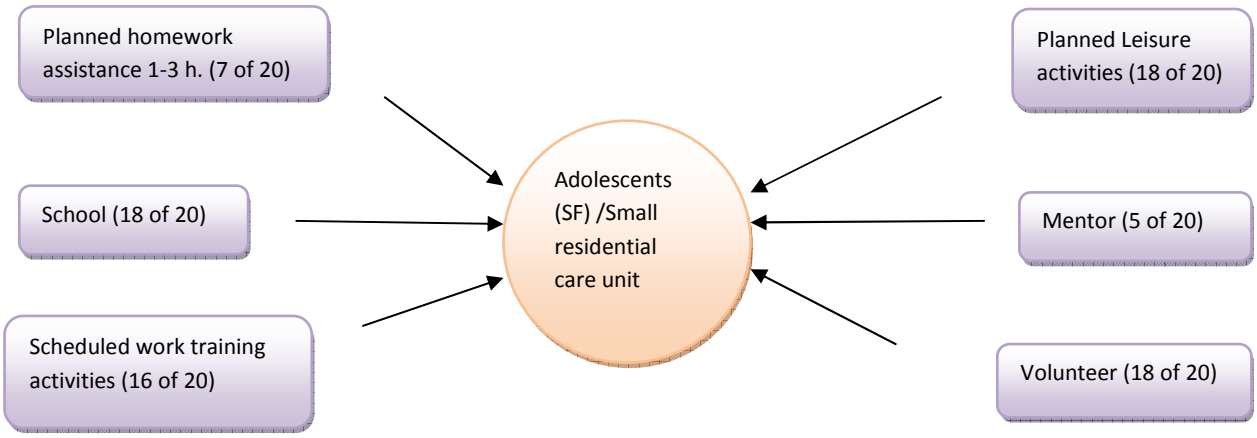
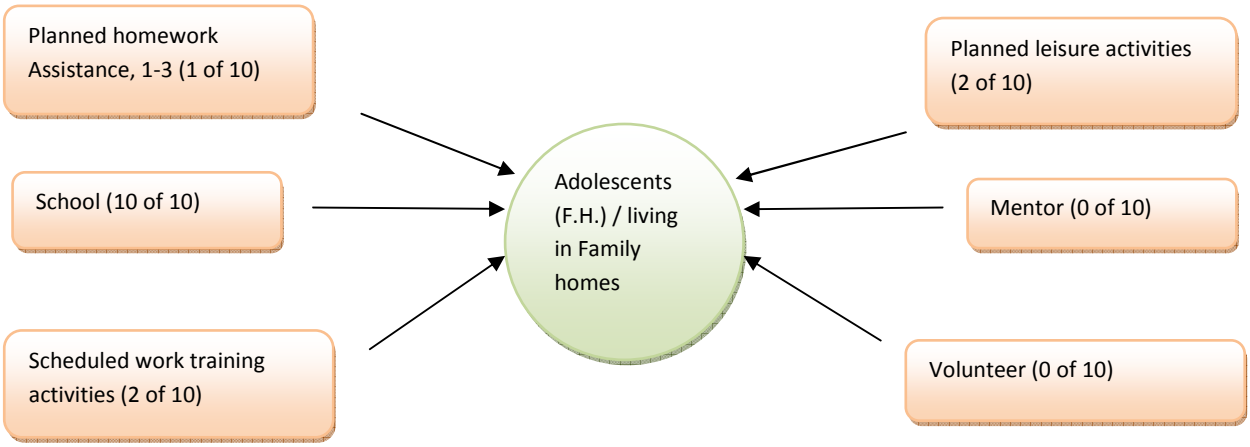


Figure 2. Adolescent, living in family homes, who were engaged in different activities to facilitate their adaptation in the Swedish society,



In Table 3 is presented the differences between adolescents´ establishment/ adaptation processes who were placed in SF and FH.

Table 3. Community establishment indicators

	20 UAM at SF Residential Care		10 UAM living in Family Homes	
	Yes	No	Yes	No
Getting help with homework	18 (90%)	2	2 (20%)	8
1-3 hours weekly help with homework at home	7 (35%)	13	1 (10%)	9
Getting help with leisure activities	18 (90%)	2	1 (10%)	9
The number of internship / 1 or 2 times	17 (85%)	3	2 (20%)	8
Having a volunteer	18 (90%)	2	0 (-)	10
Having a mentor	5 (25%)	15	0 (-)	10

Table 4 presents how the family homes characteristics were when it came to job situation of the family heads. This study shows that 40 percent of the family fathers and 60 percent of the family mothers were jobless. The adolescents who were living in these families were not satisfied living there. A total of 90 percent of adolescents answered no or both yes and no to the question: "Do you like living in your family home?"

A majority (80 to 90 percent) of adolescents living in family homes had not received any help with homework, school contacts, leisure activities and contacting health services. The results shows that placing these adolescents in such a families giving them a worse start in adapting into Swedish society.

Table 4. Family homes characteristics

	Yes	No	Yes and No
Does the father in the family work?	2	4	-
Does the mother in the family work?	2	6	-
Do you like living in your family home?	1	3	6
Have you received help with homework?	2	8	-
Have you received help with you school contacts?	1	9	-
Have you received help with leisure activities?	1	9	-
Have you received help to contact health services?	2	8	-

Utilization of Mental Health Services

The adolescents who participated in this study were exhibiting different kinds of physical and psychological problems. A research question for this study was if the adolescents exhibited symptoms of stress, anxiety and depression. The result showed that this seemed to be the case. Each depression scale has 10 or more items identifying if participants exhibiting

any psychological problems. The items are presented in Appendices III and IV. As presented in Table 5, a majority of adolescents in both groups (80 %) were suffering from mild, moderate or difficult depression based on MADRS. The mean for the total group was 1,67 with a standard deviation of 1,1. The data from PHQ-9 give similar result as MADRS, namely that 73,4 % of participants werer suffering from moderate, difficult and very difficult depression during two weeks prior to the study. The mean was 1,27 with a standard deviation of 0,9. More than 50 % of adolescents showed a problematic functioning based on GAF-scale. It means that adolescents in this study showed *moderate difficulty in social, occupational, or school functioning (e.g.. few friends, conflicts with peers or co-workers).* None of them at the time of conducting the study had an ongoing contact with a Child-Adolescents Psychiatry Center.

According to the participants themselves, in the open questions they mentioned that they felt depressed due to the family situation either back home or in other exile countries, but also fear of being alone and managing a life in an industrialized country such as Sweden. The uncertainty at the labor market was also mentioned as having a negative impact on the adolescent´s psychological well-being. Many of them tried to get a job because they wanted to help their families that they were forced to leave behind. They also had fear of being exposed by the Swedish authorities because of giving false age to the Migration Board at the time of filing for asylum. The knowledge about not being faithful and always being forced to hide something from friends and authorities raised the levels of stress and anxiety among refugee adolescents, according to answers to the open questions. A majority of those 20 adolescents living at SFs´ facilities who participated in this study assumed that they gave their correct age to The Migration Board. As a matter in fact, many of them did not know exactly how old they were, as they did not have any birth certificate. Some of them, based on what parents or relatives said, applied for a birth certificate when they were older. The Migration Board officers are aware of this issue and The Migration Board has published a statement that The Migration Board officers should look at the need of receiving asylum in the first place, and that knowing the exact age of asylum seekers is not prioritized (Migrationsverket, 2011).

Table 5. Mental health indicators and utilization of health services

Montgomery-Åsberg Depression scale/MADRS	30 UAM from SF residential care and FH, family homes
	Percent
MADRS: No depression / score 0-10	20,0
MADRS: Mild depression / score 11-20	23,3
MADRS: Moderate depression / score 21-30	26,7
MADRS: Difficult depression / score 31-40	30,0
MADRS: Mean	1,67
MADRS: Std Deviation	1,1
Depression scale / PHQ-9	Percent
PHQ-9: No depression / score 0-4	26,7
PHQ-9: Moderate depression / score 5-14	26,7
PHQ-9: Difficult depression / score 15-24	40,0
PHQ-9: Very difficult depression / score 25-34	6,7
PHQ-9: Mean	1,27
PHQ-9: Std Deviation	0,9
GAF: Global Assessment Functioning	Percent
Scored 60>	46,7
Scored 60<	53,3
Number of adolescents receiving therapy	Number
UAM in SF and FH	0

Appendix III, IV and V give more information about the numbers presented here.

Traumatic backgrounds based on qualitative data

- Morad (not real name) was 17 years old when he came to Sweden. He has been very sad and he scored high in some of core criteria in both MADRS and PHQ9. He had a history of hurting himself with a knife in Sweden. One story he talked about was that being hungry for several days in Turkey and later on board a rubber boat along with many others to Greece. They were detected by the Greek Coast guards and their rubber boat was shot at. They were in water for almost one hour and the navy guards did not try to pick them up. The Coast guards patrolled around them in the water and laughed at them. He remembered and vividly told us that some refugees drowned that day because they could not hold themselves over the water any more.

- Shirzad (not real name) is 17 years old. He is short and very pale. He is living in a family home and has huge problems keeping his school schedule and not taking drugs. He had a contact with BUP but chose to drop out in spite of BUPs´ recommendation. He talked about living alone as a refugee in Pakistan and often being drugged as a 12-13 years old boy and raped by one or several men. He said that this was his everyday life for several years.

His family home´s mom is a single mom with a sixteen years old daughter. The mom is an alcoholic, according to Shirzad, and the mom and the daughter fight very often and the daughter is acting out by being verbally aggressive to her mom.

- Ardovan (not real name) is 18 years old and living in a family home. The head of the family home is an unmarried man who is jobless and cannot talk Swedish, even after living in Sweden for eight years. Ardovan told us that he does not have an own room and he is living in the same room with that man. He feels very distressed that the man takes his food and eats it.

- Mouna (not real name) is an eighteen years old young girl. She tries to be kind to everybody and meets others always with a smile. Her scores on MADRS and PHQ9 are high in some criteria. Later during the interview she discloses that she has a little daughter in Somalia. She did not say anything about having a daughter in Somalia while filing for resident permit because she was worried to be sent back based on having a stronger connection to Somalia than to Sweden. She does not know how to bring her child to Sweden and this worries her a lot and creates concentration and sleeping problem for her.

- Fatuma (not real name) has lots of trouble with her school and do not want to go to school. She does not want to work either. She has lots of male friends, which is very taboo in Somali communities and the rumors say that she has multiple sexual relationships with different boys. She smokes and tries different kinds of drugs. She told us that she got pregnant while living in SF´s residential care and that she did an abortion. She chose by herself to marry an old and wealthy man in Somalia hoping that the man should help her to flee to Europe. After a while her husband promised her to help her to come to Europe by forcing her to send her little sister to him while she was gone. Fatuma encouraged her sister to marry the man hoping to get financial help from her husband to flee to Europe. Fatuama promised in her turn to do everything in her power to bring the sister to Europe.

  In Sweden she discovered that she did not have the energy to step up for the sister and help her to come to Sweden. Her husband instead wants her to get a resident permit for him first before he can send the sister to Sweden.

Discussion

Many of the adolescents who have been interviewed in this study have experienced major difficulties or trauma during the phase of preflight, flight and resettlement. They were coming from counties that have been in war and extreme poverty for decades. They had

experiences of being in the middle of a battle field, being abused as a free labor and losing their siblings or parents in the war. Many of the adolescents who participated in this study had heavy experiences of going hungry for days, sleeping in parks and outside home, being beaten and offended by police and authorities in the countries of their trip to Europe. Many of these children felt that they had difficulties to learn the Swedish language and to adapt to the Swedish society.

In this study I found that unaccompanied adolescent´s resistance to go to mental health services can be sought in their cultural understanding of psychological disorders, their fears of being called by their peers as a mental case, and the lack of fluency in the Swedish language which forces them to communicate with the therapist through interpreters. Communicating through interpreters can often cause a situation in the therapy room forcing the adolescents to choose either to end the therapy or to drop out. I could also see that many of those children who visited SF´s Advice Center did not have enough knowledge about the available health services in Stockholm. For instance, many of them did not know about Youth Centers –ungdomsmottagningar – and its function in Sweden. Many adolescents also mentioned a sense of not being accepted in the Swedish society and a feeling of being discriminated and met with skepticism.

UNICEF´s report (UNICEF, 2007, and Rees & Bradshaw, 2008, in McCarthy and Marks, 2010) indicates that children who are living in rich countries are not necessarily the happiest. Well-being is rather a holistic concept than domain specific. I think that even many Swedish children and adolescents in this age do not feel psychologically healthy because of the sensitivity of this period of life. According to Erik Erikson´s personality theory they may also struggle with psychosocial crises in order to find a positive identity (Hergenhahn and Olson, 1999).

UNHCR emphasizes in its report the importance of a stable and integrated system of receiving and taking care of unaccompanied children that takes into account that these children may suffer from possible traumas and exhibiting symptoms of psychological disorders (UNHCR, 2010). Lindencrona came to the same conclusion (Lindencrona and Ekblad, 2008). This study indicates too that neither SF nor Family homes were equipped with such a system.

A combination of neurological weaknesses, being involved in traumatic events and not having control over one´s own life under a long period of time may cause serious psychological and psychiatric disorders such as behavioral maladjustment, anxiety, PTSD, depression, phobia, paranoia, and schizophrenic. The health status of many of those

youngsters improves as their acculturation gets formed. Difficulties in this process include dealing with trauma, language barriers, discrimination, racism and negotiating identity in a new culture (McCarthy & Marks, 2010). In order to form a healthy new identity that works for those children and adolescents, they must go through an internal process that leads to an internal acceptance. This internal acceptance will go much faster and easier if the host society take a leading role to create an atmosphere of general acceptance. My understanding is that we have a problem when it comes to the host society´s acceptance of many immigrants, and this study group in particular. Long term psycho-pedagogical and cognitive behavioral approaches, such as social skills training, motivational interviewing, (MI), positive attention, and communication/ problem-solving training, may be useful when working with refugee adolescents and adolescents in general (O´Donohue, Fisher and Hayes, 2003, Gleitman, 2000, Veer, 1998). Aida Alayarian argues strongly that psychodynamic approach is a very useful tool working with this group (Alyarian, 2007).

Heptimstall, Sethna and Tylor (2004) in the UK found significant associations between depression among refugee children and refugee adolescents, on the one hand, and insecure asylum status and the presence of financial problems in the families, on the other (Michelson and Sclare 2009). In this study, it should be noted that in spite of exhibiting many psychological and even psychiatric problems, many of the refugee adolescents chose not to go to BUP for treatment. But many of them still showed to have a functioning life and trying hard to make good future for themselves. Resilience may be one of the factors playing role when doing good by refugee adolescents (Hodes, et. al., 2008).

Papadopoulos (2002) recommends a safe environment around these children with a structure of school and leisure time activities. But this is not enough. For these youngsters who are coming from countries with no traditions of going to mental health centers and with an avoidance of contacting a psychologist, being in a therapeutic care environment seems to be a good approach (McCarthy & Marks, 2010). This study indicates that neither The Social Service Management (SF) nor the family homes provided such a therapeutic environment for these adolescents. It is important that these adolescents can build a social network and receive information about the care system in Sweden. Having therapists incorporated in their everyday life, working closely with them seems to be a good approach that can be tested. A mobile team that goes out and meets asylum seekers and refugees in their own environment is too preferable. MAsT (BUP:s Mobila AsylTeam) in Stockholm is a good example of such an approach. MAsT is a division in Child and Adolescents Psychiatric Care system in Stockholm that has a mobile activity which means that psychiatric personals are ready to head out and

meat children and adolescents who needs psychiatric care, such as an assessment in an emergency situation or several meetings in their natural setting such as home, school and youth clubs. They combine their meetings with young patients both at the clinic and outside the clinic.

A number of adolescents in this study reported a contact of one or several hours with BUP (Child- and Adolescents Psychiatric Center), but they chose not to continue having contact. It is of importance to discuss the reasons that made the adolescents to break the contact with BUP or to drop out. One explanation is that they were not familiar with this kind of contact and having contact with a therapist might be unthinkable. A second explanation can be that the therapeutic meeting requires having interpreters in the therapy room simultaneously, interpreters who often do not have any training in therapy conversation, but also do not have proper education. My own working for more than five years closely with patients who need interpreters for conversation has been a frightening experience, but I do believe that it is possible to engage in a therapy process with an interpreter – if based on specific criteria, such as trained interpreter for a specific therapy approach, have one and the same interpreter in every session with one and the same patients, working as a team (interpreter and therapist) both inside and outside the therapy room. The third explanation may be that adolescents simply feel better compared with their previous social- and mental situation and choose to end the therapy.

The adolescents who were living in small groups of residential settings in this study seemed to have a better chance to adapt into the Swedish society compared with those who were living in family homes. A large number of adolescents participating in the current study showed a high level of depression and psychosocial symptoms. Psychosocial symptoms refers to possible contributing factors to depression based on emotional changes or changes in life pattern caused by stress related to social factors (Sallnäs, 2000, svenskaakademien.se, fub.se). It may also be seen as Erik Erikson´s psychosocial crises, with adolescents trying to create an identity with which they find a balance with their previous identity. Failing in creating a positive identity causes long lasting psychosocial disorders (Hergenhahn and Olson, (1999), Eysenck, 1998). As it is presented in result section many of adolescents, from both groups, who participated in this study exhibited different kinds of psychological and psychosocial based problems on different items of depression scales but none of them were receiving any psychological or psychiatric help according to their self report. However it is important to mention that many of those adolescents in this study reported that they had a contact with

BUP in the beginning of their coming in Sweden but they chose to drop out or to end their contact.

Most of the adolescents participating in this study received their resident permit in less than 6 months, many of them in three months. No one of them reported a long lasting or a present difficulty based on the asylum application process. Montgomery (Denmark), Billing (Sweden), Laban (Netherlands) and Michelson (England) reported in their studies that a time-consuming asylum process had a negative impact on the asylum seeking children´s overall health situation, particularly their mental health (Montgomery, 2005. Billing, 2008. Laban, 2008. Michelson and Sclare, 2009).This was not the case in this study because of the relatively short-time asylum process. Instead there were clear indicators that post-migration factors such as lack of work, family-related issues, acculturation and internal identity process or internal identity crises, and external social factors, had a negative impact on adolescents overall health situation (Montgomery, 2005; Billing, 2008; Laban, 2008; Michelson & Sclare, 2009).

According to the findings in this study, the refugee adolescents placed a great value on education and work. The majority of the adolescents were aware of the importance of learning the language of the host country, and getting an education in order to get into labor market. This conclusion is based on data in Figures 1 and 2 that 93 % of the adolescents continued to go to school and 27 %) had planned homework assistance between 1-3 hours a week. In table 3 it was shown that more than 66 % of adolescents received homework assistance. Based on the result of this study it is possible to draw conclusion that many of those refugee adolescents were motivated and knew what they must achieve in order to succeed, because they voluntary engaged in different activities such as having a mentor, a volunteer, getting homework and not having school dropout. This will of course be much easier for them if the host society has suitable programs in place to take care of the youngsters. The reason that some of these adolescents being involved in traumatic events managed to create a healthy life for themselves in Sweden may be sought in their resilience. Aida Alayarina pointed out some characteristics that make resilient people strong enough to deal with everyday life. They have a good cognitive capacity to distinguish between fantasy and reality. Resilient adolescents can use different strategies to control the surrounding environment. They have a good sense of humor and they are aware of those negative feelings they experience within themselves. Other characteristics are their positive thinking and their not wanting to be identified as victims (Alayarian, 2007).

Michelson and Sclare found that the reason for underutilization among this group can be sought in parents´ and caregivers´ different understanding of definition of distress, impairment or psychological disorder in contrast to what we understand in western society about this issue. They also mentioned that unaccompanied and companied children with a lack of fluency in English find it hard to engage in a psychotherapy treatment process. The children´s limited knowledge of available services, mobility and also the refugees´ experiences of discrimination from the host society are also some of the reasons that may explain children´s underutilization of health care services (Michelson and Sclare, 2009). Ehntholt and Yule (2006) report the importance of having an integrated approach to these children and adolescents based on *case management*, *psychoeducation* and *integration of culturally-appropriate* concepts of distress and recovery constitute key components of care alongside psychotherapy (Michelson and Sclare, 2009, p.278). Using strategies for having conversation with children and adolescents in their normal daily setting is of importance when interaction with children in general and with refuge children / adolescents in particular (Iwarsson, 2007).

Billing in his study found that asylum seeking children and even their parents, who have been affected of negative experiences in their past, benefit of having some kind of psychotherapeutic care as soon as possible (Billing, 2008). Papadopoulos defines psychotherapeutic care as having a psychotherapeutic reflective thinking in interaction with this group and adapting psychotherapeutic care as it suite them (Papadopoulos, 2002 in Billing 2008). It means that when it comes to adolescents in this study -who seemingly have a resistance to go to psychiatric clinics- will benefit of meeting social workers/professionals with psychotherapeutic education in their everyday life. Marie Sallnäs found in her study that the living standard and social support of unaccompanied asylum seeking adolescents were a bit lower in family homes compared with Swedish family (Sallnäs, 2010). The current study shows that the living standard and social support were much lower in family home compared with adolescents living in FS:´s facilities with twenty four hours professional support system.

In working with unaccompanied children in small residential care, a combination of professionals having academic education in the field of pedagogy and psychology seem to be a good combination, also based on UN recommendation. There is an urgent need to investigate and to study privately held small residential care with a few places and also big institutions, with many places for children with personals without an academic education for the field, in order to see how it affects children who are living in those facilities.

Monica Jacobsen and Lars Olssen showed in their study that refugee children often reported being exposed to abuse and exploitation. They drew the conclusion that *"children´s grounds for protection are not taken into account in the asylum procedure"* (Fryklund & Lundberg, 2009. P. 250). We can see also in our study that adolescents´ needs of psychological help are not met appropriately after receiving resident permit. There is no system in place by SF in its residential facilities to detect and work with adolescents exhibiting psychological distress, anxiety or depression. This study shows that only adolescents – living in small residential facilities at SF- with a clear alcohol or substance abuse had a better chance to receive professional help. As Goldin and many others put it, "*Trauma-stress exposure during both war and resettlement presented as an unequivocal risk to mental health"*, which is a part of outcome variance in his dissertation report (Goldin, 2008). As Ottawa conference pointed out, one of the greatest health promotion actions by governments receiving asylum seekers is to *"recognize health and its maintenance as a major social investment and challenge, and address the overall ecological issues of our way of living"* (Lindencrona, 2008, p. 43).

The results reported in this study suggest that we need to have a comprehensive and nationwide program to address all different psychological, social, and financial issues of new-coming, especially unaccompanied refugee adolescent in order to give them a fair chance to establish a healthy contact with Swedish society. The current system to receive and integrate refugee adolescents in Sweden is one of the top systems in world class. With some adjustments in this system we can make it even better.

Weaknesses and strengths of the study

The study is a pilot study with few participants. The limited number of participants in this study set limitations to generalizability. I am aware that the study findings cannot be generalizable to the experiences of all unaccompanied adolescents. Still, I believe that the study is a good first step in providing better information about these adolescents and that future studies with larger samples can use the findings reported to select the best possible instruments.

We assume that those adolescents who came to The Advisor Center were youngsters who experienced difficulties in their family homes and could not get the help they wished for. That was the reason they sought us. Probably adolescents who were living in good and functioning family homes did not feel any need to come and visit us. Based on this assumption, it is probably the case that the study group of adolescents who visited the Advise

Center was biased – they probably had a worse life situation in Sweden than the adolescents who did not visit the center.

The strengths of this design are that my being as a study conductor would not be considered as an outsider who is working with this ethnic group. Being both a community staff, working with this group and in the same time being in a research group, studying these participants is a strong advantage (Saks & Allsop, 2010). Coming from the some ethnic group and having a similar background raises the probability to engage and ask questions relevant to their culture which in turn increases the chances to gather more accurate information via open interviews.

Designing questions are of importance. For instance we cannot ask an adolescent the questions such as: Are you happy about how you have been treated by Migration Board, Or by your local social security officer? If we ask these questions in the beginning of an interview or if we put these questions in the beginning of a questionnaire we will most probably get a positive answer from a majority of study participants. Why? We know that most of those youngsters who are coming from totalitarian and military societies do not trust any authority figure. Most of them unfortunately see the research group as authority figures. Further, many of them are not familiar with the fact that universities and state /community organizations are two separate entities that do not normally have any information exchange with each other that can cause a problem for the participants. That is why this is important that interviews start with easy and open questions such as: How is your life in this facility? Or tell me about your life in general? As Mark Johnson says, working with community members builds capacity, confidence and a sense of ownership within communities, which can be sustained after a project has finished. It also strengthens researcher´s position working on issues of public health (Saks & Allsop, p. 346, 2010). Remember: Work *with* ethnic groups not *on* them. That is why my being there *with* them, working *on* the issue is of importance.

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Appendix I

RBS- Enkät / Resultatbaserad styrning

1. När blev ungdomen inskriven?
2. Har ungdomens psykiska hälsa utretts? Ja Nej
3. Har ungdomen en psykisk eller fysisk sjukdomsdiagnos eller skada? Ja Nej Vet ej
4. Är ungdomen i behandling, dvs följer ungdomen läkarordination för en psykisk eller fysisk diagnos / skada? Ja Nej Vet ej
5. Antal akuta sjukhusbesök sedan senaste mättillfället.
6. Har ungdomen varit inblandad i händelser som lett till polisanmälan som brottsoffer? Ja Nej Ja, mer än en gång
7. Har ungdomen varit inblandad i händelser som lett till polisanmälan som förövare? Ja Nej Ja, mer än en gång
8. Har ungdomen vid två eller fler tillfällen sedan senaste mättillfället, krävt vård pga
   - Ätstörningar
   - Sömnsvårigheter
   - Självmordsförsök
   - Missbruk
   - Självskadligt beteende (skadar sig själv fysiskt)
   - Nedsatt impulskontroll
   - Panikångest eller liknande
   - Annat
9. Ungdomens… (flera alternativ är möjliga)
   - Har arbete
   - Har praktik
   - Går i skolan
   - Arbetar/går i skolan
   - Praktiserar/går i skolan
10. Har ungdomen under en aktuella perioden haft ogiltig frånvaro från sin sysselsättning?
    - Ja, mer än 20 procent
    - Nej, om det är mindre än 20 procent
    - Uppgift saknas
11. Hur gör du när du ska söka jobb? Kan svaret Kan svaret delvis Kan ej svaret
12. Vad är lön? - - -

13. Vad är bidrag?	-	-	-
14. Hur gör du för att leta boende?	-	-	-
15. Vad händer om du inte betalar hyra Eller el i tid?	-	-	-
16. När ska hyran betalas?	-	-	-
17. Vart anmäler du flytt?	-	-	-
18. Hur gör du för att få personbevis?	-	-	-
19. Hur gör du när du deklarerar?	-	-	-
20. Hur gör du för att få skattejämkning?	-	-	-
21. Vad är försäkringskassan?	-	-	-
22. Vad är en frivilighetsorganisation?	-	-	-
23. Vad ska du göra om du är i en nödsituation?	-	-	-
24. Vad händer om du gör något illegalt (begår ett brott)?	-	-	-
25. Vad händer om du blir utsatt för ett brott?	-	-	-
26. Vad kan socialtjänsten hjälpa dig med?	-	-	-
27. Vad kan man få hjälp med en ungdomsmott.?	-	-	-
28. Hur gör du för att betala dina räkningar?	-	-	-
29. Vad innebär det att ha betalningsanmärkning?	-	-	-

Appendix II

Familjehemfrågor / släktplacering / ej släktplacering

1. Var bor du någonstans?
2. Hur länge har du bott där?
3. Hur många bor i huset?
4. Vad har du för anknyttning till värden?
5. Hur många barn bor i huset?
6. Hur gamla är barnen?
7. Vad har familjefadern/ familjemodern för sysselsättning?
    - Bor ej med mig
    - Arbetar
    - Arbetslös
    - Sjukskriven
8. Trivs du bra där? Ja Nej Så där
9. På vilket sätt hjälper familjen dig i din vardag?
    - Läxhjälp Ja Nej Ibland/ till en viss del
    - Fritidsintresse - - -
    - Vårdkontakter - - -
    - Skolkontakter - - -

Appendix III

MADRS – Montgomery-Åsberg Depressionskala

1. Sänkt grundstämning
Avser sänkning av det emotionella grundläget (till skillnad från situationsutlösta affekter). Omfattar dysterhet, tungsinne och nedstämdhet som manifesterar sig i mimik, kroppshållning och rörelsemönster,
Bedömningen baseras på utpräglingsgrad och avledbarhet.

0 Neutralt stämningsläge.
1 –
2 Ser genomgående nedstämd ut, men kan tillfälligt växla till ljusare sinnesstämning.
3 –
4 Ser nedstämd och olycklig ut oavsett samtalsämne.
5 –
6 Genomgående uttryck för extrem dysterhet, tungsinne eller förtvivlad olycka.

2. Nedstämdhet
Avser uppgift om sänkt grundstämning oavsett om den tar sig yttre uttryck eller ej. Omfattar känslor av sorgsenhet, olycklighet, tungsinthet, hopplöshet och hjälplöshet. Bedömningen baseras på intensitet, varaktighet och i vilken grad sinnesstämningen påverkas av yttre omständigheter.

0 Neutralt stämningsläge. Kan känna såväl tillfällig munterhet som nedstämdhet, alltefter omständigheterna, utan övervikt för det ena eller det andra stämningsläget.
1 –
2 Övervägande upplevelser av nedstämdhet men ljusare stunder förekommer.
3 –
4 Genomgående nedstämdhet och dyster till sinnet, Sinnestämningen påverkas av yttre omständigheter.
5 –
6 Genomgående upplevelser av maximal nedstämdhet.

3. Ångestkänslor
Avser känslor av vag psykisk olust eller en obehaglig inre spänning, ångest, skräck eller inre oro, som kan stegras till panik. Bedömningen baseras på intensitet, frekvens, duration och behov av hjälp. (Särhålles från 2. Nedstämdhet).

0 Mestadels lugn.
1 –
2 Tillfälliga känslor av obehaglig psykisk spänning.
3 –
4 Ständig känsla av inre oro, någon gång stegrad till panik, som endast med viss svårighet kan bemästras.
5 –
6 Långdragna panikattacker. Överväldigande känslor av skräck eller dödsångest, som ej kan bemästras på egen hand.

4. **Minskad nattsömn**
   Avser uppgifter om minskad sömntid eller sömndjup i förhållande till de ordinära sömnvanorna.

   0 Sover som vanligt.
   1 –
   2 Måttliga insomningssvårigheter eller kortare, ytligare och/eller oroligare sömn än vanligt.
   3 –
   4 Minskad sömntid (minst 2 timmar mindre än normalt). Vaknar ofta under natten även utan yttre störningar.
   5 –
   6 Mindre än 2-3 timmars nattsömn totalt.

5. **Minskad aptit**
   Avser upplevelser av att aptiten är sämre än normalt.

   0 Normalt eller ökad aptit.
   1 –
   2 Dålig matlust.
   3 –
   4 Aptit saknas nästan helt, maten smakar inte, måste tvinga sig att äta.
   5 –
   6 Måste övertalas att äta något överhuvudtaget. Matvägran.

6. **Koncentrationssvårigheter**
   Avser svårigheter att samla tankarna eller koncentrera sig. Bedömningen baseras på intensitet, frekvens och i vilken mån olika aktiviteter försvåras.

   0 Inga koncentrationssvårigheter.
   1 –
   2 Tillfälligt svårt att hålla tankarna samlade vid t ex läsning eller TV-tittande.
   3 –
   4 Uppenbara koncentrationssvårigheter, som försvårar läsning eller samtal.
   5 –
   6 Kontinuerliga, invalidiserande koncentrationssvårigheter.

7. **Initiativlöshet**
   Avser den subjektiva upplevelsen av initiativlöshet, känslan av att behöva övervinna att motstånd, innan en aktivitet kan påbörjas.

   0 Inga svårigheter att ta itu med nya uppgifter.
   1 –
   2 Lätta igångsättningssvårigheter.
   3 –
   4 Svårt att komma igång även med normalt enkla rutinuppgifter, men som nu kräver stor ansträngning.
   5 –
   6 Oförmåga att ta initiativ till de enklaste aktiviteterna. Kan inte påbörja någon verksamhet på egen hand.

8. Minskad känslomässigt engagemang
Avser upplevelser av minskat intresse för omvärlden eller för sådana aktiviteter som vanligen bereder nöje eller glädje. Subjektiv oförmåga att reagera känslomässigt inför människor eller företeelser i omgivningen.

0 Normalt intresse för omvärlden och för andra människor.
1 –
2 Svårigheter att finna nöje i sådant som vanligen väcker intresse. Minskad förmåga att bli arg eller irriterad.
3 –
4 Ointresse av omvärlden. Upplevelser av likgiltighet inför vänner och bekanta.
5 –
6 Total oförmåga att känna adekvat sorg eller vrede. Total eller smärtsam likgiltighet och förmåga att uppleva känslor även för närstående.

9. Depressivt tankeinnehåll
Avser självförebråelser, självanklagelser, föreställningar om synd och skuld, mindervärdighet och ekonomisk ruin.

0 Inga pessimistiska tankar.
1 –
2 Fluktuerande självförebråelser och mindervärdesidéer.
3 –
4 Ständiga självanklagelser. Klara, men inte orimliga tankar om synd eller skuld. Uttalat pessimistisk framtidssyn.
5 –
6 Absurda föreställningar om ekonomisk ruin och oförlåtliga synder. Absurda självanklagelser.

10. Livsleda och självmordstankar
Avser upplevelser av livsleda, dödsönskningar och självmordstankar samt förberedelser för självmord. Eventuella självmordsförsök påverkar ej i sig skattningen.

0 Ordinär livslust. Inga självmordstankar.
1 –
2 Livsleda, men inga eller endast vaga dödsönskningar.
3 –
4 Självmordstankar förekommer och självmord betraktas som en tänkbar utväg, men ingen bestämd självmordsavsikt.
5 –
6 Uttalande avsikter att begå självmord, när tillfälle bjuds. Aktiva förberedelser för självmord.

11-20	Lätt depression
21-30	Måttlig depression
31-40	Svår depression
41-50	Mycket svår depression

Appendix IV

Depressionsenkät (PHQ-9)
Under de senaste två veckorna, hur ofta har du besvärats av något av följande problem. (0) inte alls (1) flera dagar (2) Mer än hälften av dagarna (3) Nästan varje dag

1. Lite intresse eller glädje i att göra saker	0	1	2	3
2. Känt dig nedstämd, deprimerad / Känt att framtiden ser hopplös ut	0	1	2	3
3. Problem att somna/vaknat i förtid Sovit för mycket	0	1	2	3
4. Känt dig trött eller energilös	0	1	2	3
5. Dålig aptit eller att du ätit för mycket	0	1	2	3
6. Dålig självkänsla – eller att du känt dig Misslyckad / att du svikit dig /din familj	0	1	2	3
7. Svårighet att koncentrera dig, t ex när du Läst tidningen eller satt på TV	0	1	2	3
8. Att du rört dig eller talat så långsamt Att andra noterat det? Eller motsatsen – Att du har varit nervös eller rastlös att du Rört dig ner än vanligt.	0	1	2	3
9. Tankar att det skulle vara bättre om du Var död eller att du skulle skada dig på Något sätt	0	1	2	3

Om du kryssat för att du haft något av dessa problem, hur stora svårigheter har dessa problem förorsakat dig på arbetet, eller för att ta hand om sysslor hemma, eller i kontakten med andra människor?

Inga svårigheter	vissa svårigheter	stora svårigheter	Extrema svårigheter
0	1	2	3

0-4	Ingen depression
5-14	Måttlig depression
15-24	Svår depression
25-30	Mycket svår depression

Appendix V

GAF – skalan / Global funktionsskattningsskala

Beakta psykologiskt, social och yrkesmässigt funktionsförmåga längs ett hypotetiskt kontinuum, där psykisk ohälsa respektive psykisk sjukdom utgör de bägge delarna. Inkludera ej sådan funktionsnedsättning som beror på somatiska begränsade faktorer eller på yttre begränsade faktorer.

OBS! Använd även mellanliggande skalsteg, t ex 45, 68, 72

100-91	Synnerligen god funktionsförmåga inom vitt skilda områden, livsproblem förefaller aldrig bli ohanterliga, andra söker sig till personen pga hans /hennes många positiva egenskaper. Inga symtom.
90-81	Frånvaro av symtom eller minimala symtom (t ex lätt nervositet inför en tentamen), god funktionsförmåga i alla avseende, intresserad av och engagerad i ett antal olika aktiviteter, socialt kapabel, allmänt sett tillfreds med tillvaron, endast vardagliga problem eller bekymmer (t ex tillfälliga konflikter med anhöriga).
80-71	Om några symtom föreligger så rör det sig om övergående och förväntade reaktioner på psykosociala stressfaktorer (t ex koncentrationssvårigheter efter familjegräl); endast obetydliga funktionssvårigheter med avseende på sociala kontakter, arbete eller skola (t ex tillfälligt på efterkälken med skolarbete).
70-61	Vissa lindriga symtom (t ex nedstämdhet och lindriga sömnbesvär) eller vissa funktionssvårigheter med avseende på sociala kontakter, arbete eller skola (t ex tillfälligt skolk, stulit från annan familjemedlem), men i stort sett tämligen välfungerande, har några etablerade, betydelsefulla personliga relationer.
60-51	Allvarliga symtom (t ex flacka affekter och omständligt tal, enstaka panikattacker) Eller måttliga funktionssvårigheter med avseende på sociala kontakter, arbete eller skola (t ex har endast få vänner, har konflikter med kollegor eller arbetskamrater).
50-41	Allvarliga symtom (t ex självmordstankar, svåra tvångsritualer, frekventa snatterier) Eller allvarliga funktionssvårigheter med avseende på sociala kontakter, arbete eller skola (t ex inga vänner alls, oförmågen att behålla ett arbete).
40-31	Viss störning i realitetsprövningen eller av kommunikationsförmågan (t ex uttrycker sig tidvis ologiskt, oklart eller irrelevant) Eller uttalade funktionssvårigheter i flera avseenden, såsom arbete och studier, familjerelationer, omdöme, tankeförmåga eller sinnesstämning (t ex en deprimerad man som undviker sina vänner, försummar familjen och är oförmögen att arbeta; ett barn som ofta ger sig på yngre barn, misslyckas i skolan och är trotsigt hemma.
30-21	Beteende avsevärt påverkat av vanföreställningar eller hallucinationer Eller allvarlig störning av kommunikationsförmågan eller omdömet (t ex stundtals

	osammanhängande, beter sig gravt inadekvat, ständiga suicidtankar) Eller oförmögen att fungera i snart alla avseenden (t ex ligger till sängs hela dagen; inget arbete, ingen bostad, inga vänner).
20-11	Viss risk att individen tillfogar sig själv eller andra skada (t ex suicidhandlingar utan uppenbar dödsförväntan; ofta våldsam; maniskt uppskruvad) Eller stundtals oförmögen till elementär personlig hygien (t ex kladdar med avföring) Eller grav störning av kommunikationsförmågan (t ex mestadels osammanhängande eller mutistisk).
10-1	Ständig risk för att individen tillfogar sig själv eller andra allvarliga skador (t ex återkommande våldsamhet) Eller ständigt oförmögen till elementär personlig hygien Eller allvarlig suicidhandling med uppenbar dödsförväntan.