

*Patients' Perspectives of the Work of
The Refugee Children's Team in Gothenburg*

Master's thesis in Medicine

Ida Håkansson¹

Supervisors:

Henry Ascher^{1 2} MD, PhD

Vania Ranjbar^{1 2} PhD

*¹Section for Epidemiology and Social Medicine,
Dept. of Public Health and Community Medicine,
Sahlgrenska Academy, University of Gothenburg, Sweden*

²Angered Hospital, Sweden



UNIVERSITY OF GOTHENBURG

Programme in Medicine

Gothenburg, Sweden 2015

TABLE OF CONTENTS

ABSTRACT	3
INTRODUCTION	4
REFUGEE CHILDREN – DEFINITION	4
REFUGEE CHILDREN IN SWEDEN	6
HEALTH DIFFICULTIES IN REFUGEE CHILDREN	6
THE SWEDISH LAW CONCERNING ASYLUM AND THE RIGHT TO HEALTH AND SOCIAL CARE	9
THE REFUGEE CHILDREN’S TEAM IN GOTHENBURG	10
THE AIM OF THIS STUDY	13
METHODS	14
STUDY DESIGN.....	14
RECRUITMENT AND DATA COLLECTION	14
<i>Recruitment</i>	14
<i>Interviews</i>	18
DATA ANALYSIS	19
Benefits regarding the treatment of the patient.....	20
Improvements regarding treatment.....	20
ETHICAL CONSIDERATIONS	21
RESULTS	22
FIGURE 3. OVERVIEW OF MAIN THEMES AND SUBTHEMES.	23
BENEFITS EXPERIENCED BY THE PARTICIPANTS	24
<i>Benefits regarding the treatment of the patient</i>	24
<i>Benefits regarding other aspects of the care given</i>	28
SUGGESTIONS ON IMPROVEMENTS EXPERIENCED BY THE PARTICIPANTS	30
<i>Improvements regarding treatment</i>	30
<i>Improvements regarding the transfer to adult mental health</i>	34
<i>Issues to bear in mind when treating refugee children</i>	35
<i>Practicalities to be improved</i>	38
DISCUSSION	39
BENEFITS EXPERIENCED.....	39
IMPROVEMENTS SUGGESTED BY PARTICIPANTS	40
LIMITATIONS OF THE STUDY AND SUGGESTIONS FOR FURTHER RESEARCH	44
CONCLUSION	46
POPULÄRVETENSKAPLIG SAMMANFATTNING	48
ACKNOWLEDGEMENTS	50
REFERENCES	51
APPENDIX A	53
APPENDIX B	54

ABSTRACT

This study aimed to investigate the work of the Refugee Children's Team from the refugee children's point of view. By using a qualitative method with semi-structured interviews, the ambition was to highlight the benefits, if any, of this service as experienced by children and adolescents who had completed their treatment at the service, as well as to elicit their suggestions for possible improvements in the team's work.

Six interviews were conducted and analysed using thematic analysis, which resulted in six main themes: benefits regarding the treatment of the patient, benefits regarding other aspects of the care given, improvements regarding treatment, improvements regarding the transfer to adult mental health, issues to bear in mind when treating refugee children and practicalities to be improved.

The results showed that the experiences of treatment offered by the Refugee Children's Team differed considerably across different individuals/patients. When the treatment had been experienced as most beneficial, it had been supportive of building a secure base in one's new life in Sweden, so that the integration process into society as well as making friends and contacts could continue. One of the most important factors for experiencing the care as beneficial and helpful was for patients to gain confidence in their health care provider and that a trusting relationship was developed between them, whereby patients felt safe and comfortable while telling their story. The study's findings also indicated that the routines for involving patients in deciding the main focus as well as in the choice of treatment could be improved.

Keywords: refugee children, children's mental health care, patient-centered care, trauma

INTRODUCTION

Everyday around the world, children are forced to leave their homes, their countries and sometimes their families to escape from threats such as persecution, oppression, war, human rights violations, catastrophes and poverty. By the end of 2013, an estimated 16.7 million persons were refugees worldwide, and close to 1.2 million asylum seekers. Children below 18 years constituted 50 per cent of the refugee population that year, which is the highest figure in a decade (1). Of all refugees, more than half came from three countries: Afghanistan, Syrian Arab Republic and Somalia. As much as 86 per cent of the world's refugees were hosted by developing countries (1).

When refugee children arrive in a new country, where they perhaps seek asylum, they carry with them experiences that may cause different needs for help and support compared to other children in general. For example, they may have experienced violence, traumas, separations and loss, as well as be suffering from feelings of guilt, which all may affect their health, development and function in everyday life. The question of how to best organise the care for refugee children, both for children in families and those unaccompanied, is therefore of great importance in the present situation in Sweden and in the world. This subject is therefore in need of more investigation. Hence, this study aims to investigate the work of the Refugee Children's Team in Gothenburg, Sweden, from the refugee children's point of view.

Refugee children – definition

In this thesis, the phrase *refugee children* refers to children up to the age of 18 years, who have come to Sweden with family members or by themselves as unaccompanied minors to escape various threats in their country of origin. This is partly based on the definition of this phrase as applied in the Swedish Aliens Act (2) – which in turn is mainly based on the definition by the United Nations (UN) (3). In this act, a *refugee* is a person outside the

country of their nationality, or if not having a nationality, outside the country of their former habitual residence, owing to well-founded fear of being persecuted for reasons of race, religion, nationality, gender, sexual orientation, membership of particular social group or political opinion. The person should also be unable or, owing to such fear, unwilling to avail himself/herself of the protection of that country.

Asylum can be given, according to the Swedish Aliens Act (2), if one is recognised as a refugee. One could also be granted asylum if deemed a foreigner in need of subsidiary or other protection and not able to receive protection from one's country of origin. For children, the Migration Board should try children's grounds for asylum separately from their parents' grounds. The Aliens Act also states:

In cases involving a child, particular attention must be given to what is required with regard to the child's health and development and the best interests of the child in general.

In assessing questions of permits under this Act when a child will be affected by a decision in the case, the child must be heard, unless this is inappropriate. Account must be taken of what the child has said to the extent warranted by the age and maturity of the child. (4)

However, in this thesis *refugee children* will also include children who have fled but have not sought asylum at all or have not been granted a residence permit in their asylum process. Usually this group of people, staying in the country without legal permission for different reasons, is called *undocumented migrants*. Undocumented migrants are not seen as refugees by Swedish law, even though some of them may have fled to Sweden from difficulties in the country where they used to live. The reason for choosing this wider definition in this thesis is because the Refugee Children's Team, whose work this study aims to investigate, accepts all these children as patients if they have symptoms and needs that the team could help with, even though they are not refugees in a strict legal sense.

Refugee children in Sweden

Over the last years, the number of asylum seeking children in Sweden has increased, from nearly 6,600 in 2009 to almost 16,500 in 2013, and for unaccompanied minors from nearly 2,300 in 2009 to almost 3,900 in 2013 (5, 6). In 2013, the children were most commonly from Syrian Arab Republic, Eritrea, Somalia and Afghanistan but a large group was stateless. The unaccompanied minors were most commonly from Afghanistan (6).

In July 2014 the Swedish Migration Board announced that the prognosis of expected number of asylum seekers in Sweden (both adults and children) had to be raised due to increased number of asylum applicants compared to the corresponding period of previous year (7). The main cause of this increase is the on-going conflicts in Syrian Arab Republic and Eritrea, where most of these refugees come from. These developments also have consequences in the form of an increase in number of unaccompanied minors, and the prognosis for this category was therefore raised from 4,400 to 6,500 for 2014 (7).

The increase of asylum seeking children in Sweden will most likely also increase the number of children living as undocumented migrants, as a consequence of not all children obtaining a residence permit. The number of children living as undocumented migrants in Sweden today is not known. A report from the National Board of Health and Welfare from 2010 refers to research that estimates that 10,000 to 50,000 persons live as undocumented migrants, and of these 2,000 to 3,000 are estimated to be children (8). As the number of refugee children in Sweden is increasing, the need for increased knowledge of how to care for and help these children in different parts of society is of great importance.

Health difficulties in refugee children

As noted, refugees are often subjected to traumatic and stressful events. Upon arrival in a host country new stressors, such as worries related to an on-going asylum seeking process and/or

worries for family members or relatives, are added to the already difficult situation. Even though young refugees are often both resilient and resourceful, many experience mental health difficulties, such as post-traumatic stress disorder (PTSD), depression, grief and anxiety (9). In a review article from 2005 looking at the prevalence of serious mental disorders in refugees resettled in western countries, five studies regarding PTSD in children were identified (10). The studies provided data from a total of 260 refugee children in three countries (Canada, USA and Sweden) and showed that overall 11 % (7-17 %) of refugee children were diagnosed with PTSD (10).

When offering help and support to refugee children upon arrival in their new host country, it is important to have knowledge of some of the risk and protective factors that have been found to have an impact on these children's mental health. In a review article published in 2012 (11) looking at displaced and refugee children's mental health when resettled in a high-income country, exposure to violence was shown to be a key risk factor. Although violence exposure before migration is the most common risk factor, repeated exposure to violence and lack of safety soon after migration or displacement also play a central role. Another risk factor is perceived discrimination in the host country. Moreover, uncertain asylum status has been found to be associated with several psychological problems, like distress in children. The importance of developing policies for shortening the asylum seeking process from application to decision is emphasised by the authors (11). It is also important to bear in mind that being an unaccompanied minor is found to be a risk factor for developing mental health problems, indicating that this group tends to be especially vulnerable (11). The increased exposure to risk factors among refugee children is likely to contribute to the increased prevalence of mental health disorders in this group of children (11).

Enabling stable settlement and the possibility to gain social support on different levels in the host country have a positive impact, as the most common protective factors for the

children shown are parental support, family cohesion, support from friends and positive school experience. The identification of factors contributing to resilience in refugee children is important for the development of successful interventions aiming to reduce mental health problems among these children. Interventions that enable mobilising and developing already existing adaptive systems within children, families and communities are said to be key. These interventions, therefore, not only require psychotherapeutic skills but also need to focus on, for example, ensuring acceptable housing and easing the integration process as well as offering psychosocial interventions such as skills training (11).

Another study, based on interviews with asylum seeking children in Sweden about their thoughts on health (12), concluded that the most important factor for promoting health in this group was supporting the children's parents in their parental role. This was based on the children highlighting their parents to be the most important factor for feeling good and being healthy. The second most important factor was school, where children find friends and meet caring teachers. Also the importance of education for their future in Sweden was mentioned as an important aspect of school. The third most important positive factor according to the study was the spare-time – to play and socialise with friends and have fun instead of thinking about worries. Having things to do in their spare-time was, however, often dependent on financial factors and where they lived, for example if there was a football team in their town or if they needed to travel elsewhere and then needed money for the journey. Factors that had the most negative impact on the asylum seeking children's health and wellbeing, according to their own opinion, were nightmares and painful memories, as well as family separation and worries about those family members who were not with them in Sweden, financial problems in Sweden and the feeling of alienation from society, not being able to go to school and worries about the future.

The Swedish law concerning asylum and the right to health and social care

Asylum seekers, refugees with residence permits and undocumented migrants have different legal rights and sometimes different access to health care, which could affect their health. Because children are also affected by their parents' health and access to health care, it is important to bear in mind adults' legal rights to health as well as children's legal rights in Sweden. Legal status could therefore be of great importance for the ability to achieve good health as it affects one's daily life as well as the possibility to plan for the future. This should be taken into consideration when discussing different causes of mental or physical illness.

According to the Health and Medical Services Act in Sweden (13), health and medical services should be available to the whole population, on equal conditions. Health services should be given with respect to human rights and the person with the most needs should be given priority (13). Despite this, there are special laws regarding asylum seekers and undocumented migrants concerning health care, whereby adults in this group are not granted the same right as the rest of the population (14, 15). Regarding individuals under the age of 18 years, they have the same right to health and medical services as the rest of the population, irrespective of their legal status (if they are asylum seekers, have a temporary residence permit, wait for deportation, are in a detention centre or are undocumented migrants) (14, 15). Sweden has also ratified the Convention on the Rights of the Child (16, 17), where it is written in article 24 that:

States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. (17)

Since June 2013, all children living in Sweden, including undocumented migrants, have the right to go to school, including pre-school and upper secondary school (18). Regarding social

care, the local authorities in each municipality in Sweden are responsible for supporting all people staying within the municipality, according to the Social Services Act (19). However, the Act does not specifically address undocumented migrants or their children; therefore, it is up to each local authority to decide whether undocumented migrants (both adults and children) should receive social assistance or not. Asylum seekers can apply for financial support from the Swedish Migration Board to cover food expenses (depending on if the accommodation provided by the Migration Board offers food or not), costs for medical and dental care and medicine, other consumables and leisure activities (20).

In Sweden, children and adolescents up to the age of 18 years with mental illness can seek help and support from the Child and Adolescent Psychiatry care (Swedish abbreviation “BUP”, Barn- och Ungdomspsykiatri) in each region. If one suffers from symptoms caused by physical illness too, one needs to seek care from a paediatric outpatient clinic as well. Hence, newly arrived refugee children often meet many different people in different places and may have to tell their story over and over again, which could be hard. In Gothenburg, refugee children with symptoms that could be caused by both mental and physical illness are taken care of by paediatricians and psychologists that work together in the same team, called the Refugee Children’s Team, as an attempt to reduce this problem and with a holistic perspective get a better overview of the child’s health, social situation and needs.

The Refugee Children’s Team in Gothenburg

The Refugee Children’s Team in Gothenburg started its work in 2008 and is run in collaboration between the Paediatric Outpatient Clinic of Angered Hospital and BUP in the area of Gamlestaden in north-eastern Gothenburg. The team works at the request of the Health and Medical Care Committee in north-eastern Gothenburg, and is part of the tax-financed public health care system. According to the request, the Refugee Children’s Team

should be a medical and psychosocial specialist team with the purpose of strengthening and improving the work with refugee children who are newly arrived in Sweden and Gothenburg.

The team's commission is to do medical and psychiatric examinations of refugee children (up to the age of 18 years) and their families and offer help, advice and treatment if that is needed. To be accepted as a patient one needs to exhibit symptoms of mental and physical illness. The patients are referred to the team mainly from social workers, the school health services and primary health care services. The contact with the team starts with a medical and psychiatric assessment by one or two team members, who then together with the patient and the patient's family decide what kind of help and treatment the child and the family need. The help offered could be regarding the children's social situation, school and everyday life as well as specialised trauma treatment. The team's work is based on the UN Convention of the Rights of the Child, and the wishes of the child and the family should be a starting point for the help and support offered. The team also has the commission to spread knowledge and raise awareness of issues concerning migration, living as a refugee child and trauma. Their resources comprise almost five full-time positions distributed across psychologists, a social worker, paediatricians, a nurse and a medical secretary.

In 2013, the Refugee Children's Team received 120 referrals, of which 92 were called for a first visit (21). Those not accepted as patients at the team were referred to other health care units, especially to other BUP. Finally 88 children made their first visit to the team, as four children declined to come. Of these, approximately two thirds were unaccompanied minors and one third came with their family; likewise, two thirds were boys and one third was girls. A majority of the children were between 13 to 17 years old and most of them came from Afghanistan, Somalia, Syrian Arab Republic and Iran. A majority of the patients were asylum seekers, approximately one third of the patients had a residence permit and only about one tenth of the patients were undocumented migrants. Their physical and mental health varied

considerably, but the most common physical problems were constipation, enuresis, avitaminosis (lack of vitamins) and bacterial infections. The most common psychiatric diagnoses were related to stress disorders and depression, for example PTSD (21).

In 2013, about 80 patients concluded their treatment period at the team. The length of the treatment period as well as the number of visits the patients had at the team varied considerably. The average length of treatment period was 39 weeks with 10 visits, but 15 patients only visited the team once and 22 patients visited the team between 13 and 41 times (21).

The Refugee Children's Team has as of 2014 been operating for six years. The team's work has, however, not yet been evaluated from their patients' point of view. A recent master's thesis focused on unaccompanied minors as patients at the Refugee Children's Team (22). The study is retrospective and based on medical records, with the aim to increase knowledge about unaccompanied minors and their contact with the Swedish health care system. As such, the study is entirely based on the staff's point of view and others referring children to the team.

According to the study, the unaccompanied minors constitute a highly vulnerable group, which is in line with earlier research as well (23). As a group they therefore have specific needs, although their resilience should not be overlooked, which also have been pointed out in earlier research (24). Some had experienced war, but much more common were experiences of loss of important family members, having witnessed physical violence or having been subjected to physical violence. The children in the study showed symptoms of both physical and mental problems, which could be linked to their previous experiences. The children were in need of help and care at different levels, such as support and consultation regarding their life situation and mental state, help with co-ordination and communication between different actors in society who were helping them, practical help with their everyday

life in Sweden as well as legal help with the asylum process and trauma treatment. With regard to the latter, the study suggests that it is of great importance that these children receive help from health workers that are well-educated and experienced in trauma treatment, psychosocial work and cultural meetings in the health care system, as well as knowledge about the asylum process; this is something that many refugee children experience difficulties with and worry about (22).

The study also suggested that an important topic of investigation for future research is the care needs of the unaccompanied minors from their own point of view, as well as their experiences and views of the care they have received from the Refugee Children's Team. Previous research (25) has highlighted this lack of research whereby unaccompanied minors are given the opportunity to tell about their experiences and needs.

The aim of this study

Accordingly, the purpose of this study is to investigate the work of the Refugee Children's Team in Gothenburg, from the refugee children's point of view, as part of the team's quality assurance. The ambition is to highlight the benefits, if any, of this service as experienced by the children and adolescents, as well as to elicit their suggestions for possible improvements in the team's work. The study therefore aims to address the following research questions: what, if any, are the benefits of the Refugee Children's Team for their patients, and what could be improved in the team's work?

METHODS

Study design

As the focus of this study was to investigate the work of the Refugee Children's Team from the refugee children's point of view, a qualitative method with semi-structured interviews was chosen (26). Semi-structured interviews give the possibility to ensure inclusion of the main issues in relation to the study purpose, by having a list of questions to base the interview on, but it is still possible to omit or add questions, as well as giving the participants the opportunity to freely direct the conversation (26).

Recruitment and data collection

Recruitment

Participants were recruited from the team's medical records by five members of the team of which three were psychologists, one was a paediatrician and the final one was a social worker. Inclusion criteria were that participants should have completed their treatment at the service and be able to participate in an interview in Swedish; due to lack of resources, the study was not able to make use of an interpreter. We also aimed to recruit participants from various countries if possible, and achieve balance with regard to gender, age (over and below 15 years), family status (children coming to Sweden with their families versus as unaccompanied minors) and legal status (with or without residence permit when starting their treatment at the service). The aim was to collect accounts from many different perspectives. The selected prospective participants were sent a recruitment letter with information about the study and also that the nurse within the Refugee Children's Team was going to contact them via telephone a couple of days later to give more detailed information, answer questions and ask if they wanted to participate in the study. According to Swedish laws concerning research

ethics, if the prospective participant was under the age of 15 years, two information letters were sent: one addressed to the caregiver(s) or legal guardian in a more formal language, and one addressed to the child in a language suited for children and adolescents. Once the nurse had been in contact with the prospective participants, names and contact details of those accepting to participate or wanting more information about the study were forwarded to the researcher who contacted the prospective participant via telephone. If the prospective participant was under the age of 15 years, contact was initiated with a caregiver or legal guardian and only upon permission did the researcher speak to the child. If the prospective participant accepted to take part in the study, a time and location for the interview was arranged.

The initial aim was to recruit between 10 and 20 participants. This number was chosen due to the time limit of the study, since qualitative methods produce rich data resulting in time-consuming, in-depth analyses (27). Twenty-two recruitment letters were sent out, but only 12 of these prospective participants were possible to reach by telephone. Those not reached by telephone were sent a new letter, informing them that the nurse had tried to call them and that they were asked to call the nurse back if they were interested in participating in the study. Of the 12 reached, 9 accepted to take part in the study. However, 2 of these were not possible to reach again by telephone in order to make interview arrangements. One of the 9 prospective participants was also excluded due to pragmatic difficulties concerning language and the study's short time frame. This resulted in 6 participants, all of whom participated in one individual interview each. The 3 who declined to participate gave reasons such as lack of time or language difficulties. Due to time constraints it was not possible to extend the recruitment. An overview of the recruitment process is shown in Figure 1 below. Sample demographics are presented in Table 1.

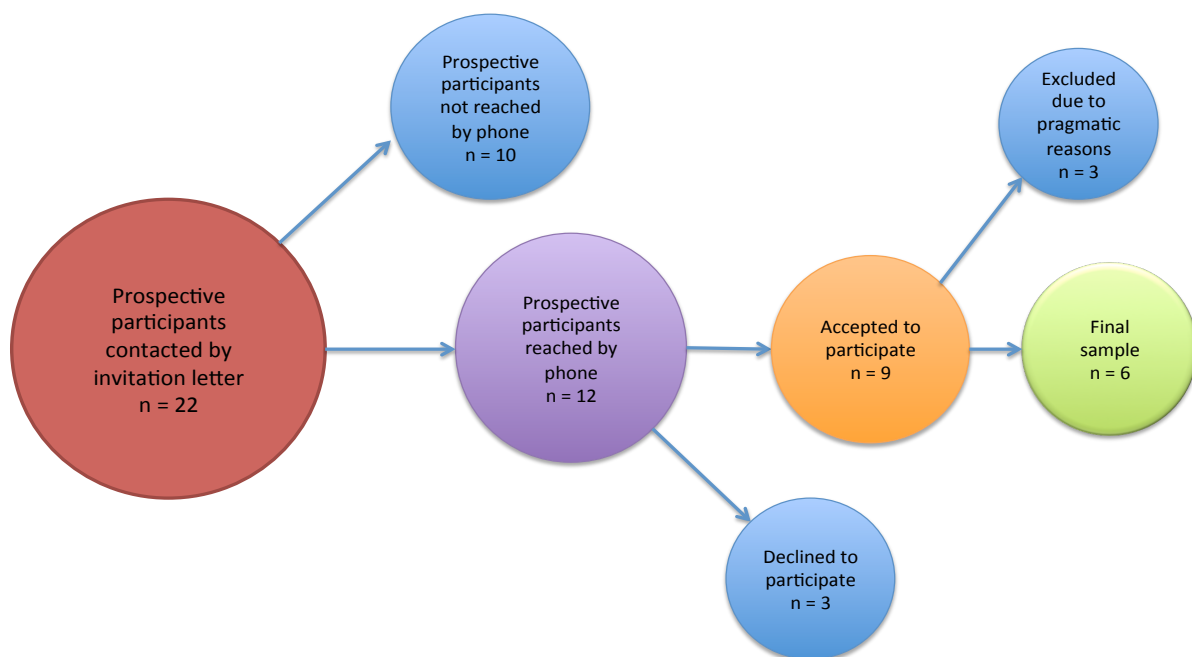


Figure 1. Overview of the recruitment process.

Table 1. Sample demographics.

Demographic	n (%)
Sex	
Girl	2 (33.3)
Boy	4 (66.7)
Other	0 (0)
Age*	
11 years	1 (16.7)
16 years	1 (16.7)
18 years	2 (33.3)
20 years	2 (33.3)
Country of origin	
Iraq	1 (16.7)
Afghanistan	3 (50)
Palestine	1 (16.7)
Somalia	1 (16.7)
Family status	
Unaccompanied minor	4 (66.7)
With family	2 (33.3)
Residence permit when starting treatment	
Yes	3 (50)
No	3 (50)
Residence permit at the time of study	
Yes	6 (100)
No	0 (0)
<hr/>	
* Mean age	17.2 years

The final sample of participants was demographically similar to the initial group of prospective participants contacted by letter. In comparison to the group of prospective participants not reached by telephone, however, the sex imbalance was somewhat lesser in the sample (33.3 % girls and 66.7 % boys in the sample versus 20 % and 80 % respectively in the drop-out group), the mean age was a couple of years lower (17.2 versus 19.7 years with no

one below 15 years in the drop-out group) and a smaller proportion of the sample was unaccompanied minors (66.7 % versus 90 % in the drop-out group).

Interviews

The interviews took place either at the office of Angered Hospital, at a public library or in the participant's home, depending on the request of the participant. They lasted for about one hour, except for one interview that lasted only approximately 15 minutes, because of the wish of the participant. The interviews were initiated with an information session and participants were provided with a Participant Information Sheet, upon which written consent was obtained. In cases where the participant was under the age of 15 years, a caregiver or legal guardian took part in the information session and also signed the consent form. Caregivers or legal guardians were not present during the interviews except for in one case because the participant wanted the caregiver to remain present during the interview.

The interviews were semi-structured to ensure inclusion of the main issues in relation to the study purpose. A list of questions (see Appendix A for the questions in Swedish and Appendix B for the questions translated in English) was used by the researcher, but it was possible to omit or add questions, and participants were free to direct the conversation. In five of the six interviews, all main questions were addressed. The list of questions used was put together by the author together with the supervisors.

All interviews, except for one, were audiotaped and transcribed verbatim by the author. One participant did not feel comfortable being recorded; hence one interview was not audiotaped. Instead, the researcher took notes during and immediately after the interview (from memory). One of the audiotaped interviews was conducted over the telephone at the request of the participant (who did not want to be seen by anyone during the interview). In

order to ensure confidentiality, all personal names and geographical descriptions were excluded during transcription.

All participants received two cinema gift vouchers each for their participation.

Data analysis

To analyse the qualitative data, thematic analysis was conducted based on the method described by Braun and Clarke (28) and with the help of NVivo version 10.0.3. Thematic analysis was used in an inductive approach, whereby themes were identified in a “bottom-up” manner based on a “process of coding the data without trying to fit it into a pre-existing coding frame, or the researcher’s analytic preconceptions” (28). Compared to theoretical or deductive analysis, whereby the analysis is done in a “top-down” manner and analyst-driven, the inductive form of thematic analysis is data-driven (28). The transcription as well as the analysis was performed by the author, and finalised after consultation with the supervisors.

The first step focused on familiarising oneself with the data and began during the transcription process, followed by reading and re-reading the data, while taking notes and marking relevant data extracts related to the research questions. Second, the data extracts and notes collected were used to produce a list of codes, as each extract got a code reflecting its content and meaning. Next, other relevant extracts from the rest of the data were collated to the identified codes. After this, the codes were sorted and grouped together in categories, according to similarity, thus forming potential themes. As the process went on, main themes and subthemes were identified. Finally, themes as well as subthemes were reviewed on two levels: first from top to bottom, to ensure that the themes reflected the overall meaning and content in the codes and extracts within each theme, and second from bottom to top to see that the collated extracts formed a coherent pattern together, reflected in the overarching theme. While reviewing the themes, the whole data set was reread once more, to ensure that no

relevant data extract had been missed in the earlier coding process, but also to see that the themes identified accurately reflected the meanings of the data set as a whole. Extracts presented in the results were selected and translated by the author. When choosing extracts, the aim was to illustrate the main themes and subthemes with representative extracts, but also to have a spread of extracts among the participants. As mentioned, one participant did not want to be recorded during the interview. Therefore, no extracts are presented from that interview, but the participant's contribution was included in the analysis. An example of the analysis process is visualised in Figure 2.

Extract	Code	Subtheme	Main theme
<p>Extract 6: Neymar: (...) I think that, she was...one who said to me that I should start in BUP, because I had a lot of nightmares... Interviewer: Mm. Neymar: Things like that... Interviewer: Mm. Neymar: I couldn't sleep so much by then. Interviewer: No. Neymar: But now it has passed.</p>	<p>Nightmares before, but better now</p>	<p>Better physical and mental health</p>	<p>Benefits regarding the treatment of the patient</p>
<p>Extract 19: Asoma: (...) when I, this person if, when says it is done ... Interviewer: Mm... Asoma: ... I call, I call (little laugh)... Interviewer: (laughing) Asoma: ...after one year, "how does it work your, how does it work?" Interviewer: Mm. Asoma: ...because, one does not know if, for example if one finished, eh, as I say "It is finished" and after one week, had it really big problem, much problem...</p>	<p>Wish for follow-up over phone, new problems may have arisen</p>	<p>Improvements regarding follow-up after treatment</p>	<p>Improvements regarding treatment</p>

Figure 2. Example of the analysis process of the data.

Ethical considerations

The study protocol was reviewed by the University of Gothenburg as well as the Research Ethics Committee of Angered Hospital.

Collecting data via qualitative interviews allows the understanding of someone's opinions and perspectives on a deeper level regarding a specific topic. When deciding upon semi-structured interviews for this study, it was taken into account that as the study focuses on participants' experiences from the past, there was a risk that the interviews would awaken painful memories and affections in participants. The fact that this group of children and adolescents, who have in common that they all have experienced flight, war or other kinds of trauma related to being a refugee, could be more vulnerable compared to children and adolescents without such experiences was considered as well.

The study was however neither focusing on nor asking about these experiences, but instead aiming to explore the experiences of being a patient at the Refugee Children's Team. Furthermore, it was stressed several times during the recruitment of participants, as well as while informing participants before the interviews started, that they were free to decide whether they wanted to answer the questions or not and that they could end the interview whenever they wanted without any consequences. Additionally, participants were informed that if they wished help or support after the interview, relating to their experience of participating in the study, they could contact either the Refugee Children's Team or the supervisors of the study, who then would refer them to the appropriate care. The interviewer also tried to be as attentive as possible to participants' reactions during the interviews in order to adapt or omit specific questions according to each situation, or to end the interview if inappropriate to continue, bearing the child's best interest in mind.

On the other hand, in the ethical balance, it was also taken into account that even though refugee children could be a particularly vulnerable group of children, it is nevertheless

important for them to tell their story from their own perspective and to be heard in all matters affecting them (17). It is also important to have in mind that troubling memories, which could be awakened during an interview, still exist whether or not one participates in a research interview. Moreover, this group's experiences are of great importance for gaining better knowledge about the life and difficulties that refugee children face, as well as for improving the support given to this group. Having the latter in mind, it could, on the contrary, be argued to be irresponsible and unethical not to do research concerning these issues, since withholding information about refugee children's own opinions on their needs will make essential improvements neither possible to identify, nor to be realised (29).

RESULTS

The analysis resulted in six main themes with subthemes, described below organised according to the research questions. The main themes identified were: benefits regarding the treatment of the patient, benefits regarding other aspects of the care given, improvements regarding treatment, improvements regarding the transfer to adult mental health, issues to bear in mind when treating refugee children and practicalities to be improved. An overview of the main themes and subthemes are shown in Figure 3. In extracts, participants' names are replaced with a pseudonym of their own choice.



Figure 3. Overview of main themes and subthemes.

Benefits experienced by the participants

Benefits regarding the treatment of the patient

Having someone to talk to who really listens and is respectful. Most of the participants talked about the importance of having someone to talk to about both experiences in their country of origin as well as from the flight, but also about problems in their new lives in Sweden. The benefits of having someone to talk to were of different types. The most common was that talking to the Refugee Children's Team in one way or another made the participants feel better – both in terms of feeling calmer and because talking was essential for not feeling even worse. Several participants felt that the team had listened to all their problems and helped to solve them, that there was not anything they had missed. Even if the health care provider was not able to solve all problems, participants still reported feeling somewhat better to at least talk about them.

Extract 1:

Asoma: Yeah, but it is good to say, I, I don't know before that I have arrived, I don't know how should I talk, should I say eh, eh...my problem...but if you say what, if you talk, if you talk someone and tell I have this problems, there, you got solution but, if you silence you feel pain in...

Interviewer: Okey.

Asoma: Yeah.

Interviewer: That it becomes more like it's doing, that it becomes worse if you don't talk?

Asoma: Yeah, yeah.

Getting comfort, help and care from a health care provider was mentioned as being of crucial importance for coping with one's life situation.

Extract 2:

Olle:,I have told you that, eh...I tried to, well, one or two times that going to kill myself. Because I have talked to this person, I've got a lot of help, from (health care provider).

Interviewer: Mm.

Olle: So...right now I have a good life. I've got my apartment, I've got well...yeah! I go to school, I learned Swedish...I don't need an interpreter right now (laughing)!

Feeling welcome or safe with the team, as well as getting a friendly reception from the staff, was something often mentioned during the interviews. To know what will happen during appointments was expressed as something that made participants feel safe with the team. For example, to know that one will be asked what kind of help one wants and also be able to

influence decisions taken, as well as be treated with respect regardless of what one chooses to talk about. The permissive atmosphere, to be allowed to feel and express whatever feeling one had, was appreciated, as this made one feel accepted.

Extract 3:

Maria: And eh...there I could cry, hours without anyone coming and tell that, "oh (nickname), you are a crying girl"...it was not what they...they used to say, yes, you are allowed to cry.

Interviewer: Yeah.

Maria: And...that it that it is normal.

(...)

Maria: And...eh..even though I became moody or angry, I not talk BUP in a good way, they were not angry with me back (...).

For children coming to Sweden as unaccompanied minors, the importance of having someone to talk to, who shows that one cares and tries to understand, was emphasised, as this made participants feel less lonely. To know that the health care provider would call if the patient did not show up was a way of feeling that they cared. Having the opportunity of spreading knowledge about what happens in their country of origin was also mentioned as something positive.

Extract 4:

Interviewer: (...) how did you think it was to sit and talk like that?

Ibrahim: It is common. I like to tell...

Interviewer: Mm.

Ibrahim: ...this because...there is many children there, in refugees that...

Interviewer: Mm.

Ibrahim: ...that yeah, have been in this war...

Interviewer: Mm.

Ibrahim: ...and they are in war, there is war there too in (country of origin), all...

Interviewer: Mm.

Ibrahim: ...and show all people that there are children that, that (neighbouring country) kills, that (neighbouring country) does so, that throws rockets on and does, does like that... I told it has happened something with me there in (country of origin)...

Better physical and mental health. Most of the participants told that they experienced better physical and mental health after their treatment period at the Refugee Children's Team. A benefit expressed was for example being better at coping with practical situations in life as a consequence of not feeling a constant stress and tension anymore; for example, if subjected to teasing or provocation by peers, it was easier to ignore the irritation instead of becoming angry at the person.

Extract 5:

Interviewer: (...) What has been the most important thing for you when seeing the Refugee Children's Team? Would you say?

Ibrahim: To eh...to eh, I want, well, been like that all the time, I was all the time stress, I had stress all the time, so.

Interviewer: Mm.

Ibrahim: Out of nowhere, I am stressed...

Interviewer: Mm. (...)

Ibrahim: Eh...they have helped me with this, it was important for me, to get rid of that stress, I always have stress...

Interviewer: Mm.

Ibrahim: If one talked to me, yeah, I directly got nervous and so...

Interviewer: Mm.

Ibrahim: What...eh, wha-...from nowhere, I hit, I fight, I...

Interviewer: Mm.

Ibrahim: Then, when mom went with me with this, I became new, yeah, as usual, yeah, if someone (...) earlier, if someone tried to annoy me, "What are you doing?!" so, I want to fight, so...

Interviewer: Mm.

Ibrahim: But now, it, I, it usual, I like, I never stress! Never!

Other examples of daily routines that worked better, as a positive outcome of better mental health, were being able to sleep better and having less nightmares as well as being able to concentrate in school and doing one's homework. Moreover, just growing new hope and feeling calmer, happier and that life was good after an appointment with the team was emphasised as a benefit.

Extract 6:

Neymar: (...) I think that, she was...one who said to me that I should start in BUP, because I had a lot of nightmares...

Interviewer: Mm.

Neymar: Things like that...

Interviewer: Mm.

Neymar: I couldn't sleep so much by then.

Interviewer: No.

Neymar: But now it has passed.

Receiving advice and helpful suggestions on how to handle hard situations. Several of the participants talked about the benefit and importance of receiving advice and helpful suggestions on how to handle difficult situations associated with being a newcomer in the Swedish society, and what to do to let go of painful thoughts and memories. The advice mentioned as helpful could be practical, such as breathing techniques when feeling stressed, exercises to focus on the body to let go of tension, writing down troubling thoughts or reading books or playing computer games to distract oneself from worries for a while. It could also be

about ways of thinking to cope with problems to make their lives in Sweden easier, both in terms of understanding the Swedish society as well as to cope with painful memories and worries about one's family and friends in the country of origin or in other places.

Extract 7:

Ibrahim: ...and so. I've seen a few times, in front of me, rockets that...kill people, like that on the floor, so, like that

Interviewer: Mm.

Ibrahim: And I, I, I, I think all the time there...

Interviewer: Mm.

Ibrahim: ...about that, and I...well, it was a bit hard for me to forget this...

Interviewer: Mm.

Ibrahim: ...and there I eh, could tell first everything that has happened to me, they, like they helped me with some things, "You should do like this, so, so, forget this, play computer games instead or eh, read books" like, like that

Interviewer: Mm.

Ibrahim: Yeah.

Interviewer: Some practical advice kinda?

Ibrahim: Yeah, yes.

Help to build a secure foundation in life. The help and support given by the Refugee Children's Team were also pointed out as important for making participants wanting to stay in Sweden and to be a part of the Swedish society, as all the difficulties one faces, especially as an unaccompanied minor and newcomer in Sweden, otherwise could feel too much to handle on one's own. As an illustration, one participant told that she thought it was so hard to live in Sweden that it was better, after all, to go back to her country of origin – even though she had fled from war. After receiving advice and support from the psychologist at the team, however, she gained new insights.

Extract 8:

Asoma: Yeah, because if you have help for example, you know when you have come here...

Interviewer: Mm.

Asoma: ...and everything is difficult for me, I had nobody help me, I have, I had eh, bad legal guardian (laughing a little) and bad teacher.

Interviewer: Mm.

Asoma: Eh, yeah...everything is difficult for me.

Interviewer: Mm.

Asoma: And then I thought that I, I said, I thought "If I haven't got residence permit, I'm gonna go to my homecountry", I said myself and...

Interviewer: Okey.

Asoma: ...then I met the (health care provider), and (health care provider) explain me everything, then I understood, then I, I left behind me everything that I think...yeah.

Interviewer: Ah, so then you didn't feel that you want to go back any longer, or?

Asoma: No.

The support from the team was also said to be helpful in order to stop isolating oneself and instead wanting to be a part of society and with friends, which was mentioned to be one reason for feeling less stressed after the treatment period.

Extract 9:

Interviewer: Mm. Ah, what do you think about the Refugee Children's Team?

Ibrahim: Yeah, it is good, because I've been there...

Interviewer: Mm.

Ibrahim: ...and eh... I think that I... I feel, before, I feel, I was, I feel bad, and now...

Interviewer: Mm.

Ibrahim: ...after, I, I feel like, it is usual, yes, I go in, into the usual society

Interviewer: Mm.

Ibrahim: And I... I've got friends and so on.

Interviewer: Mm.

Ibrahim: I wasn't like before, like I didn't want to be with anyone and like that... I've learned a lot of things there.

Benefits regarding other aspects of the care given

Some of the participants reported receiving help from the Refugee Children's Team in form of having a spokesperson from the team when being in contact with other authorities, which was said to be very beneficial and of great importance. For example, one of the participants received help from his psychologist who wrote a letter to the Swedish Migration Board, which he perceived to have contributed to his parents obtaining residence permits and being allowed to come and live with him in Sweden.

Extract 10:

Olle: Ehh...(clears his throat) It was a lot, I mean I got a lot of help from, from there. My eh...

The biggest thing, that I got help from, from there, it is that, eh, (health care provider) has written a letter to me, and that letter goes to...eh, goes to...eh, what it is called...the Migration Board. And, eh, it happened that eh, mine parents who were in (country of origin)...

Interviewer: Mm.

Olle: ...they got residence permit in Sweden, and they went immediately...

Interviewer: Mm.

Olle: ...from (country of origin) to Sweden. That...that is mine, that is my biggest help that I got from (health care provider). And I am very thankful of (health care provider).

Another benefit mentioned was the possibility of getting help also for siblings, who also may have had difficult experiences from one's country of origin.

Extract 11:

Ibrahim: (...) then I told about my little sister...

Interviewer: Mm, yeah.
Ibrahim: She, it has happened something with her like that in (country of origin)...
Interviewer: Mm, okey.
Ibrahim: Then, she began to tell them...
Interviewer: Okey.
Ibrahim: ...they helped her too.
Interviewer: Ah...
Ibrahim: Yeah, they were very kind.

Finally, the Refugee Children's Team allowing patients to choose an interpreter with whom they were familiar was reported as beneficial. To be able to choose an interpreter who had previously interpreted for a patient at other authorities and in school enabled that the interpreter could clarify what had really been said, as the interpreter already knew a lot about the patient's situation, which could decrease the risk of misunderstandings. The interpreter could also be "a witness" for the patient in some ways if needed. Also, the possibility to have the same interpreter at every appointment with the team was said to produce a feeling of safety for participants, as they could gain confidence for the interpreter.

Extract 12:

Asoma: Because of, yeah...eh, yeah, it is the girls that have interpreted me, being her who knows everything that happens in school.

(...)

Interviewer: Okey, so it was your interpreter there that helped you a little bit...

Asoma: Yeah, yeah...

Interviewer: ...and also to tell...?

Asoma: Yeah, yeah.

Interviewer: Ah.

Asoma: Because if I, if they eh, booked me another interpreter...

Interviewer: Yeah?

Asoma: ...they know he, she, the interpreter doesn't know what happens at school.

Interviewer: No...

Asoma: But she knows what happens.

Interviewer: Ah. Is it an interpreter that you had met before at school too?

Asoma: Yeah... And they booked only one, one interpreter when we have a meeting.

Interviewer: The same interpreter?

Asoma: Yeah, the same interpreter. About the problems.

Interviewer: Ah, did it feel good or?

Asoma: Yes.

Suggestions on improvements experienced by the participants

Improvements regarding treatment

Improvements regarding assessments of patients' need for help. To always presuppose, as a health care provider, that patients seek help because they truly feel a need for it and therefore not question their needs for help was pointed out as an improvement needed. Also important to bear in mind is that even though practical things in life, for example school, work and physical training, work well for some patients, it should not be taken for granted that their mental health is also good.

Extract 13:

Maria: (...) the other thing that I liked not, it was there that eh, they looked only at practical things, they say "aah, is it, is it going well in school, you go exercising?", ehh, "if you do those things that means you are completely healthy", no it is not like that. And, yes, I am a girl, now I am... I go to school, and that I can do, I work, I exercise, I am with my friends and my(?)... But! But! But, I'm still not well because when I'm alone, I just cry.

Interviewer: Yes.

Maria: All negative things come over me, everything I'm afraid on, and everything, well, there are some evenings, some days that I can not, because, well, well my (...??), because I don't feel anything.

Interviewer: No.

Maria: And then, in evenings, when I'm sad and dream, until now, but when I tell them, they say "Ah, everything goes fine, so what is it your problem?" No, everything is not practical, everything is not as school (weeping voice) and work and exercise/physical activity, it is not only that, that is something that really bothers me.

Improvements regarding the choice of treatment. To be cautious with psychotropic drugs when choosing treatment for patients was stressed, due to negative side effects and lack of results. Examples of negative side effects caused by antidepressants included allergy, aggravated depression and feeling too tired to do anything at all. One participant reported that feeling seriously ill from taking antidepressants made her feel hopeless about her situation. Doubts that the drugs could help at all were stressed, since drugs could not change the fact that the patient had had a difficult life.

Extract 14:

Maria: And I mostly, yeah, by the drugs I got more depressed actually.

Interviewer: Ah.

Maria: And they did it because I should not cry, I should not scream, but it was not good way to calm me down, I got addicted to the drug...

Interviewer: Okey.

Maria: ...and very depressed, couldn't be bothered to do anything, I couldn't even go to school, couldn't be bothered to do the best, the thing that I think is, yeah, thinks it is.

To reduce the focus on psychotropic drugs and whether patients take them or not was a suggestion for improvement. Also mentioned was to be cautious about asking staff at patients' accommodations to ensure that the child take their medications, as this was not appreciated. Regarding experiences of sleeping pills, pills were not always perceived to be beneficial, as they could either make one dream more than usual or did not help one fall asleep earlier in the evening, but only made one be more sleepy the following morning. Other treatment types were suggested instead of psychotropic drugs, such as more talking, suggestions of coping strategies (as alternatives to antidepressants), or support to do physical exercise, as this would aid sleep better than sleeping pills as well as being a way of handling depressive thinking.

Access to physical activities was also mentioned as a way to facilitate integration into society; for example, playing football was pointed out as a way of making new friends and learning Swedish. The biggest obstacle to be able to do sports was said to be the lack of money, especially if one is an asylum seeker or living as an undocumented migrant. Without money one could neither afford paying for a membership at a gym or swimming hall, nor buying necessary apparel. It was therefore suggested that the Refugee Children's Team should be able to help patients with financial support for physical activities, but also that the team could communicate this need to other authorities working with refugee children. This could then maybe result in discounts for this group of children at, for example, gyms or swimming halls, which was mentioned as something that would be appreciated. This kind of help was highlighted as something that, for some patients, could be more effective and helpful in improving health (both physical and mental) than either going to a psychologist or taking medications. Another suggestion was for the team to advocate agreements between accommodations for unaccompanied minors and gyms so that these children could attend them for free, so they could have more things to do in their spare time.

Moreover, it was stressed that it is important to bear in mind the diversity among refugee children and therefore important to make sure to be sensitive and perceptive when choosing the right treatment for each individual patient. Not all individuals enjoy or benefit from talking or writing about their experiences or memories, so not everyone may be helped by that. Instead they may need a pair of football shoes to make them feel better. Others, on the other hand, may only be helped by talking to someone and will not feel good even though they manage to go to school or do physical exercise.

Extract 15:

Maria: No, everyone is different, everyone isn't like everybody, I mean, all of us are not the same, some by writing down one, for those they are going to feel better, but some by telling or writing, they felt, become worse, and I was one of them, but that I hadn't, I mean, it was that that was impossible to, for them to understand that, it was for me very hard, because I, for me, if I come and tell, it means that it comes once more (...).

Improvements specifically regarding counselling. Several suggestions for improvements regarding the help and choice of treatment from psychologists have been pointed out. The most common, if a problem was mentioned, was poor communication between patients and health care providers, as experienced by patients. When patients did not feel comfortable in their communicating with health care providers, they did not gain confidence for the health care provider and therefore did not want to tell about their difficulties. One thing mentioned was that it would be easier to gain confidence in health care providers if they had personal experience of being poor or being a refugee, as this could possibly make it easier to believe that the health care provider would understand one's difficulties. Differences in power and status between patients and health care providers were also mentioned as obstacles for having confidence in health care providers and therefore also an obstacle for feeling comfortable in telling about one's difficulties.

To always let patients choose what to talk about or not talk about, as well as when, was another thing mentioned in need of improvement, since the experience of feeling forced to talk about difficult topics was described.

Extract 16:

Maria: But, but one thing, well some things that I didn't like that sometimes they forced me to eh..well the, they forced me to talk about that..well, ehm, about some things that...I, it...that I don't want to talk about them with anyone...

(...)

Maria: ...and some things embarrassing for myself to tell someone, I want it to be for myself, that I don't want anyone else to see my wounds and that I have in the heart, that ...that it was very hard for me, like after eh, after a while I stopped going to BUP...

To focus more on feelings than on practical matters was advised, as coping with negative emotions could be problematic for some patients even though practicalities in life seemed to work well.

Extract 17:

Interviewer: (...) Would you like to come and, yeah, and just tell or is there anything special you would like to get helped with?

Maria: Yes, I want help, because I am tired of this life that I have with those feelings that I have, everything goes fine, but because inside me it doesn't go so fine (weeping voice).

Interviewer: No, I understand.

Maria: And I want them to see that, that they are gonna help me because I want to have, I want to live, I don't want to die because, because I have my siblings in school(?), that thing I want. Well, it is very difficult situation, because, everything eh..(?) very big responsibility(?) for my siblings, not for practical things, but mostly with feelings and therefore I asked that someone should understand me too.

Suggestions for further improvement regarding counselling involved showing more interest and curiosity when listening to the patient, especially attending to how one use body language, as well as asking more questions instead of being silent and waiting for the patient to talk. Also stressed was that the health care provider should better ensure that the patient feels that they care and believe the patient's story. Important as well was to show that one cares by always calling patients if they do not show up for an appointment.

Extract 18:

Maria: (...) and (health care provider) told me to go to another (health care provider), other (health care provider) that (health care provider) was...crap, I sorry if I say that I crap, that I say that (health care provider) was crap...

Interviewer: No, but is okey.

Maria: ...because (health care provider) was that, (health care provider) didn't understand anything, it felt like (health care provider) is ashamed of me, of my feelings, that they are lies or what.

(...)

Maria: Well, well that, as my legal guardian, as my caregiver, she used to call (health care provider) and say, "yeah you are a (health care provider), why don't you take care of your patient?"

Interviewer: Yeah, okey.

Maria: "If she wasn't there, why then not ask for her?" Well, (health care provider) was...(health care provider) didn't care so much, not so rea-..not at all.

Improvements regarding follow-up after treatment. It was further suggested that the team should follow up patients some time after their care at the Refugee Children's Team had ended to enquire about their situation. New problems may have arisen and there is a risk that the patient is no longer able to initiate contact with the team. When asked how to best help refugee children as patients, one participant stressed that she would have called such a patient as a follow-up to check how everything was going.

Extract 19:

Asoma: (...) when I, this person if, when says it is done ...

Interviewer: Mm...

Asoma: ... I call, I call (little laugh)...

Interviewer: (laughing)

Asoma: ...after one year, "how does it work your, how does it work?"

Interviewer: Mm.

Asoma: ...because, one does not know if, for example if one finished, eh, as I say "It is finished" and after one week, had it really big problem, much problem...

Improvements regarding the transfer to adult mental health

The experience of being referred to adult mental health services immediately when turning 18 years old was not appreciated, as it was described that one did not feel as an adult yet and therefore did not feel comfortable at the adult mental health service.

Extract 20:

Maria: Yeah, because eh...I don't want to go to a psychologist for adults because...because...that, that I, I'm not...okey I am of age, but because of that, I don't think that I am an adult as the others, even though I really have turned 18, the same psychologist...

Interviewer: No, I understand.

Maria: And I don't understand either when they, in the ways the adults talk, I sometimes don't know what should I answer.

If deciding to refer an 18-year-old to adult mental health services, it was stressed that the health care provider making the referral should know the adolescent well, so that the referral is representative of the patient's condition. This is important as the referral has an impact on whether the patient receives care or not at the adult mental health services. If patients have to wait several months for the new care to start or are denied care, there may be a risk that they feel worse and abandoned.

Extract 21:

Maria: (...) I have been waiting for quite long and they (adult mental health services) are so slow, they don't care about the patients, why, because my first (health care provider), (health care provider), I had, (health care provider) I had for long, and because of that (health care provider) knew how I was outside, what I need my help, but the other (health care provider) have got (health care provider) three, four months, I, we met only a few times, so (health care provider) doesn't know what (health care provider)... (...) it feels like (health care provider) doesn't recognise me and so (health care provider) hasn't written well to other place (...)

Issues to bear in mind when treating refugee children

During the interviews, participants raised aspects of their lives for health care providers to be more understanding of or to just bear in mind. When first coming to Sweden as an unaccompanied minor, everything is experienced as new and confusing and one does not know whom to trust or not trust. Many challenges lie ahead and one may have difficulties or troubling thoughts about accommodation, education, or work. To live in an accommodation for unaccompanied minors could result in conflicts with staff or peers in the same situation. Some patients may also have younger siblings, whom they feel responsible for and need to take care of. One may not know if one will obtain a residence permit or not. Thus, health care providers need to be aware that it may be too difficult for patients to start talking about worries or painful experiences at that time. One may also have had negative experiences when attempting to tell one's story previously, which was mentioned as important to have in mind when asking questions about patients' past. It was also highlighted that one needs to be careful and show humility before the fact that one does not know what patients have gone through and what risks one might have taken to come to Sweden, especially if one is an unaccompanied minor.

Extract 22:

Maria: (...) well, there is a, a serious reason to that they have ended up here, they have taken so much risk in their lives, background they had, what had they people in life, there is something like this, they have to understand that. (...)

Another area mentioned as important for one's life situation as an unaccompanied minor was if one likes and has confidence in one's legal guardian – the legal guardian was said to be one

of the most important persons for the unaccompanied minor during the first years in Sweden. When everything is new and different from one's life before, having a person to ask questions was said to make a big difference.

Extract 23:

Olle: But eh...it is important actually, for eh...the adolescents that come, unaccompanied...

Interviewer: Mm.

Olle: ...to have a good legal guardian.

Interviewer: Mm.

Olle: It is very important for them.

Difficulties in getting enough information about how the Swedish society works was pointed out. Moreover, information about how to find one's way in town, how to travel by tram and buy tram tickets as well as advice about what kind of clothes to wear to not freeze during wintertime was needed.

To enquire whether the patient receives enough help in school in general and in learning Swedish specifically was also reported to be of great importance for patients' opportunities to be integrated in the Swedish society.

Extract 24:

Interviewer: Mm. Is there something else that is important too, that one, that one should think of, if one wants to help?

Asoma: Yeah...school.

Interviewer: School?

Asoma: Yeah, that one has good teachers, help with homeworks...

Extract 25:

Interviewer: (...) what do you think is important that one, well, what does one need...to feel good when one comes to a...new country as you have done? (...)

Ibrahim: Well, like eh, the language.

Interviewer: Yeah.

Ibrahim: The language, that one needs. Without the language, one doesn't do anything.

Having friends was also highlighted as an important part, as that helped to get out and play and get a break from troubling thoughts and worries. To get to know people and make new friends was also mentioned as a good way of getting into society, to learn Swedish and to decrease the feeling of isolation and alienation.

Extract 26:

Interviewer: (...) If, if you would give help to those children and adolescents who were in the same situation...

Ibrahim: Mm.
 Interviewer: ...or who are in the same situation as the one you were in...
 Ibrahim: Mm.
 Interviewer: ...is there something more you should have done...yourself? If you...
 Ibrahim: Mm. Like eh, do some, well, activities to them.
 Interviewer: Mm.
 Ibrahim: Yeah, go out, play together and so...
 Interviewer: Yeah.
 Ibrahim: That, that is good...
 Interviewer: Mm.
 Ibrahim: ...for them. Yes. Maybe eh...show them, well teach them, eh...some things about the society, how it works...
 Interviewer: Mm.
 Ibrahim: Not only talking, talking, talking, talking.
 (...)
 Interviewer: Yeah. What do you think, what was it that made you able to l-...like let go of the stress?
 Ibrahim: Ah...I, I started...like go into s-...Swedish society, like that...
 Interviewer: Mm.
 Ibrahim: Hang around with Swedish friends and so on...

Another thing mentioned for health care providers to bear in mind was that there could be cultural differences in how people express and show their feelings and whether it is acceptable or not to talk about poor mental health. Health care providers were advised to consider this when assessing patients' needs. For example, it was mentioned during the interviews that girls sometimes have to grow up and take care of practical things early, but they may still experience emotional difficulties. Therefore, they may not react or behave the same way when experiencing mental health problems as children of the same age who were born and grown up in Sweden.

Extract 27:

Maria: Well, that eh, well those girls, mostly the girls who are from (a continent)...
 Interviewer: Okey, yeah..?
 Maria: They are...become, they fast become mature than the others, Swedish, adolescents I ...and then they are more...with practical, practical things, they are, well one is used to for example, I am used to be in ways(?) yeah, then I'm also sad, then I'm also sad, I have to even though, I'm forced, because they forced me all the time to do. But...well, one need to try to be, have to think more(?) on feeling, not only say practical things that good, that it means that feels well. One is, one is, if one was born here, if I didn't feel good for example, ah, won't go to school, but now even I feel bad I go to, I have to go to school.
 Interviewer: Ah...
 Maria: So it is two different things.

Practicalities to be improved

One problem mentioned, regarding practicalities of the treatment offered by the Refugee Children's team, relates to time difficulties. The difficulty to find time for both school work and appointments with the Refugee Children's Team was mentioned as an obstacle for getting a sufficiently long treatment period, which could lead to patients ending their treatment period earlier than they wanted to.

Also to have in mind is that some patients may think that a long travelling distance from one's home to the team is problematic and therefore they may prefer to be referred to a BUP closer to one's home instead of having their treatment at the team.

Extract 28:

Interviewer: (...) Do you think that...that it has been...helpful for you, to go there? You have already told a bit about that...but...

(...)

Neymar: Well. It was good...but...it was good and fun, but...it was, what was not good...it wasn't...not so close.

Also mentioned was the suggestion to always offer patients the possibility to talk without family members present, both to feel able to speak freely, but also to ensure confidentiality.

Extract 29:

Interviewer: (...) So that, is there something that they could be better at, or eh... to make sure that one really can talk alone, that there isn't anyone else too, is it...?

Asoma: Mm.

Interviewer: Yeah.

Asoma: Yes, it is okay like that.

Interviewer: That they make sure that...

Asoma: Because everyone, it, it isn't the same on all the people, there are many, if you say on eh... if say your problem, they don't say ah, the other people and they are confidentiality, but it, there are also many that tell everything to other people, when you say "Yes, I have this problems" they tell the other people.

(...)

Asoma: If you and for example, I and you, I can tell everything, but, if I have someone I can't tell.

Interviewer: No, of course.

Asoma: Not telling the truth. If I have problem, I say "I haven't got problem". Yeah, like that.

Finally, concerning interpreters, the possibility of talking to a health care provider in one's mother tongue was requested. The difficulties in correctly translating expressions were

pointed out, as some words in one's mother tongue may not exist in Swedish, which could be problematic, especially when talking about feelings.

DISCUSSION

This study aimed to investigate the work of the Refugee Children's Team from the refugee children's point of view. By using a qualitative method with semi-structured interviews, the ambition was to highlight the benefits, if any, of this service as experienced by children and adolescents who had completed their treatment at the service, as well as to elicit their suggestions for possible improvements in the team's work. Six main themes were identified: benefits regarding the treatment of the patient, benefits regarding other aspects of the care given, improvements regarding treatment, improvements regarding the transfer to adult mental health, issues to bear in mind when treating refugee children and practicalities to be improved.

Benefits experienced

Overall, most of the participants stressed that they had benefited from having someone to talk to at the team who really listened and was respectful. The importance of having someone to talk to about both experiences in their country of origin as well as from the flight, but also about problems in their new lives in Sweden, was pointed out. Most of the participants reported experiencing better physical and mental health after they had finished their treatment period at the Refugee Children's Team. Moreover, several of the participants talked about the benefit and importance of receiving advice and helpful suggestions on how to handle difficult situations associated with being a newcomer in the Swedish society, and what to do to let go

of painful thoughts and memories. These benefits are in line with those identified by previous research, suggesting that this findings is not specific to the sample of the present study (12).

Help to build a secure foundation in life was a further benefit mentioned: treatment at the team was helpful for preventing isolating oneself and instead wanting to be a part of the Swedish society and socialise with friends. These findings correspond with some of the protective factors reported in a review article, where enabling stable settlement and the possibility to gain social support on different levels in the host country had a positive impact on children's psychological functioning (11). That the Refugee Children's Team focuses not only on the past but also on the patient's life situation in Sweden and problems in everyday life appears to be appreciated by patients and in line with earlier research on improving mental health.

Improvements suggested by participants

Regarding improvements, suggestions concerning the treatment included for example that the choice of treatment should be better adapted to the patient's wishes and individual needs as much and as often as possible. Most of the participants in this study pointed out that they were asked what kind of help they wanted from the health care provider and that these wishes then have been the focus of the treatment and support. Although, as not all of the participants reported this, it may be the case that patients are not always asked what problem they think is the most important and what kind of help they feel they need, or it could be the case that health care providers do not document this question in medical records, as suggested (22). Several of the participants in this study, however, had thoughts about what made them feel better or in what ways they could gain a better health. These varied from doing sports and physical exercise to having someone to talk to. These findings indicate that the routines for involving patients in deciding the main focus of their treatment as well as in the choice of

treatment could be improved. For example, formal procedures for asking patients at the beginning of the treatment period about their preferred focus of the treatment could be implemented by the Refugee Children's Team – or if such formal procedures exist, ensure these are enforced. Moreover, procedures should allow patients to reflect, during the treatment period, on what they think about the treatment so far and if something could be done differently or if they need some other kind of help, for example help with getting access to physical activities. By then, patients will hopefully feel comfortable to ask about advice or help when new problems arise.

Being cautious with psychotropic drugs was highlighted and instead more support in getting access to physical activities and more coping strategies on how to handle difficult situations and troubling thoughts and feelings was asked for. To be able to support patients financially who wish to do physical activities but cannot afford it is another suggestion, as well as offering this kind of support to all patients, as physical activity was said to reduce sleeping problems as well as strengthen the patients mentally. This corresponds with earlier research (30), since the positive effects of physical activities on mental health in children has been reported. Especially, it could be considered as an effective complement to other treatments (30).

Regarding the counselling, the most common, if a problem was mentioned, was poor communication between the patient and the health care provider. Feelings of the health care provider not being interested enough while listening, asking too few questions or, on the other hand, asking too many was mentioned. The key here seems to be to be able to adjust the amount of questions depending on both direct and indirect responses from patients and to remember that this group of refugee children is a heterogeneous group with different needs. Having staff at the team who have been refugees themselves was desired, as having personal experiences of flight was thought to be helpful in the meeting with the patient. The aspect of

letting patients choose what to talk about or not talk about, as well as when, was also mentioned as in need of improvement, which relates to improving routines for involving patients in arrangements of their treatment.

Not being sent to adult mental health services immediately when turning 18 years was also a suggestion for improvement. Perhaps such patients should be offered the possibility to continue and finish their treatment at the team. Especially, the change experienced by unaccompanied minors when they turn 18 years old and can no longer receive help from a legal guardian in combination with no longer being accepted as a patient at the Refugee Children's Team has been said to be a risk for feeling abandoned and may cause a deterioration in one's mental state. Moreover, according to their experiences of flight and traumas, as well as the findings that indicate that unaccompanied minors seem to be especially vulnerable for developing mental health problems (11, 23), this group of adolescents may not be ready to be treated as adults. Due to these findings, a follow-up of former patients who have turned 18 years old and have been transferred to adult mental health services should be considered. If problems often occur for refugee adolescents being patients of the adult mental health services, this could be the basis for more resources to the Refugee Children's Team so that the age limit could more often be adapted to the needs of each individual turning 18 years old and there could be an alternative of continuing one's treatment at the team instead of being transferred.

Regarding issues mentioned to bear in mind when treating refugee children, some aspects pointed out might also need investigation in order to get a more complete overview of what affects each patient's health situation as well as to identify difficulties where the patient could be helped by more guiding from the team. This guiding could either be help directly from the team or as helping to guide the patient to the accurate social service or authority or rather be the patient's spokesman in contact with the authority where the problem has

occurred. First, whether one gets enough information about Swedish society and everyday life in Sweden was also important to further assess. If not, the team could give patients information, advice or guide them to the right authority to receive appropriate support and information. Communication with schools could also be an important part of the treatment offered by the team, whereby health care providers at the team could be a spokesperson for patients to make sure they receive appropriate support and help in school. These issues have previously also been found to be protective factors for refugee children (11, 12), which suggests that perhaps there should be an even greater emphasis on these matters during the treatment period at the Refugee Children's Team. The importance of education in the process of resettlement for unaccompanied minors has also been pointed out in a previous study (31), where going to school was, for example, a way to learn the native language, meet friends and have a daily activity structure.

The possibility to talk to health care providers in one's mother tongue instead of having an interpreter was reported as appreciated, since the need to have an interpreter was sometimes problematic as mentioned by participants. Therefore, to investigate the possibility to employ health care providers within the team who speak some of the most common languages in the group of patients coming to the Refugee Children's Team is a suggestion for improvement.

Finally, during the interviews, some of the participants mentioned worries and stress before the first appointment at the team (data not presented) since they did not know what was going to happen at the team and what kind of questions they would be asked. Therefore, it might help to make sure to give as much information as possible to patients prior to the first visit at the team.

Limitations of the study and suggestions for further research

Due to practical restrictions, only six participants could be recruited. Furthermore, one of these did not want to be recorded and therefore the interviewer took only notes during that interview. The material from this interview was not as precise as from the recordings and could not be used as illustrative extracts in the results. With the latter in mind and only six participants in total, it is not possible to draw general conclusions about the work of the Refugee Children's Team; however, all experiences concerning the treatment given by the team could be useful for the team to gain knowledge about and to have in mind when developing their service. Nevertheless, more research on this topic is suggested, for example with a larger sample size in order to be able to identify clearer patterns, if any, and to draw more general conclusions. Using an interpreter during the interviews will most likely facilitate recruitment, as being able to participate in an interview in Swedish was one of the inclusion criteria in this study, which may have deterred some.

During the recruitment process, it was not possible to achieve that individual health care providers at the team chose equal number of prospective participants to contact due to difficulties in finding suitable participants according to the inclusion criteria. Therefore, there is a risk that the majority of the experiences and suggestions of the final sample is based on the treatment given by a minority of the health care providers at the team. Future studies should consider this kind of potential limitation and aim for a more equal distribution of participants among health care providers.

That some of the prospective participants did not want to take part in the study due to being critical of the treatment they had received is something that also needs to be taken into consideration when interpreting the results. Especially considering that participants who were most critical in this study requested not to be interviewed as per study protocols, but instead interviewed over telephone or without being audio-recorded.

A further critical limitation was the lack of possibility to have an interpreter during the interviews. All participants, except for one, revealed before the interview that they did not speak Swedish very well, and they also had difficulties finding the words they wanted to adequately describe their thoughts, experiences and feelings during the interview. Thus, it was often difficult for the participants to give a precise description of what they had experienced as well as for the interviewer to understand without asking leading questions. Participants' proficiency in Swedish also varied and because of this participants' ability to share their thoughts and opinions differed. The interview guide was also said to be in too advanced Swedish by one of the participants. Due to this limitation in communication, it needs to be taken into consideration that it is possible that language misunderstandings occurred between the interviewer and participants without either of them realising it. On the other hand, language misunderstandings can occur even when interviewers and participants have the same mother tongue. For future studies, the assistance of interpreters would be strongly recommended.

The fact that interviews took place in different settings could have had an impact on how comfortable participants felt to talk freely during interviews. Also one participant wanted to have a friend, who spoke somewhat better Swedish, present during the interview to be able to ask the friend for assistance with the language if needed. This may have affected what the participant felt comfortable discussing during the interview. One participant wanted their mother to be present during the interview, which also could have affected the interview and what was told and not told.

Also to take into account is that the interview guide was developed by the researcher/author and the supervisors. It is possible that the choice of questions may have affected the study results. Especially when participants were struggling with the language, the interview questions played a more central role.

Even though this study has limitations, many thoughts and suggestions have been shared by participants, regarding their health, the treatment offered by the Refugee Children's Team as well as what kind of help, support and treatment they need. More specific questions about the experience of different treatments offered by the team would be valuable in order to evaluate the outcomes and experiences of each of the treatments and to more clearly point out if and why they are beneficial or need improvements. Moreover, it could be of interest for future studies to investigate if needs and experiences of the treatment offered by the team differ between children coming to Sweden with their families and unaccompanied minors, in order to best adapt services to their various needs. Another suggestion for further research could be to investigate whether treatment is usually terminated on the patient's or the health care provider's initiative, as well as the reason for terminating the treatment. This, in order to determine whether treatments are terminated too early, even though the decision to end the treatment is made by the patients themselves as patients may terminate treatment due to lack of time or when very emotional despite being in need of further treatment.

Conclusion

This study has, first, demonstrated that the experiences of treatment offered by the Refugee Children's Team differ considerably across different individuals/patients. When the treatment has been experienced as most beneficial, it has been supportive of building a secure base in one's new life in Sweden, so that the integration process into society as well as making friends and contacts can continue. The Refugee Children's Team has been a place where one feels safe and receives comfort, energy and support, so that one is able to use one's own strength and resilience to develop and grow as a child/adolescent and to be able to stand on one's own. One of the most important factors for achieving such an experience seems to be that patients gain confidence for their health care provider and that a trusting relationship is

developed between them, whereby patients feel safe and comfortable while telling their story. If this communication and contact has not been the case, the treatment and help has not been experienced as helpful or beneficial.

POPULÄRVETENSKAPLIG SAMMANFATTNING

Runt om i världen tvingas barn varje dag lämna sina hem, hemländer och ibland även sina familjer för att fly från hot i form av förföljelse, förtryck, krig, brott mot mänskliga rättigheter, katastrofer och fattigdom. I slutet av 2013, var uppskattningsvis 16,7 miljoner människor på flykt i världen, och nära 1,2 miljoner av dessa var asylsökande. Barn under 18 år utgjorde 50 procent av flyktingarna under 2013, vilket är den högsta siffran på tio år enligt FN:s flyktingorgan UNHCR.

Varje flyktingbarns historia är unik, dock bär barnen ofta med sig erfarenheter som gör att de har särskilda hjälpbehov. Barnen kan exempelvis ha upplevt våld, trauman, separationer och förluster samt bära på skuld känslor, vilket kan påverka deras hälsa, utveckling och funktion i vardagen. Frågan om hur vård och hjälp till flyktingbarn bäst ges och organiseras för att möta dessa behov är därför av stor betydelse.

Denna studie syftade till att undersöka hur den vård och behandling som ges av Flyktingbarnteamet i Göteborg upplevs av teamets patienter: barn och ungdomar som flytt till Sverige och som har behov av både medicinsk och psykiatrisk vård.

I studien har kvalitativ metod använts och semistrukturerade intervjuer genomförts med barn och ungdomar som avslutat sin behandling hos Flyktingbarnteamet. Ambitionen med intervjuerna var att undersöka om Flyktingbarnteamet gör någon nytta för de barn och ungdomar de tar emot, och vilken nytta de i så fall gör. Förhoppningen var att kunna belysa aspekter av verksamheten som fungerar väl men främst vad som behöver förändras och utvecklas för att göras bättre, både på kort och lång sikt.

Totalt gjordes 6 intervjuer som sedan analyserades med tematisk analys. Analysen resulterade i att följande huvudteman identifierades: nyttor avseende behandlingen av patienten, nyttor avseende andra aspekter av den givna behandlingen, förbättringar avseende

behandlingen, förbättringar avseende överföringen till vuxenpsykiatri, faktorer att ha i åtanke vid behandling av flyktingbarn och praktiska saker som kan förbättras.

I studiens resultat sågs en stor variation mellan olika individer i hur behandlingen från Flyktingbarnteamet hade upplevts, vilket kan bero på att flyktingbarn är en heterogen grupp även om de har vissa erfarenheter gemensamt. Hos dem som upplevt sig ha mest nytta av behandlingen så hade stödet från Flyktingbarnteamet hjälpt dem att lägga en trygg grund i sina nya liv i Sverige, som de själva sedan kunde bygga vidare på. Att ha någon som lyssnar, visar respekt och vill hjälpa betydde mycket enligt många av deltagarna i studien. Studiens resultat tyder också på att en av de viktigaste faktorerna för att Flyktingbarnteamets behandling ska upplevas som till nytta för patienten är att patienten får förtroende för sin vårdgivare och att en god relation utvecklas dem emellan, så att patienten känner sig trygg och så bekväm som möjligt med att berätta sin historia. Studiens resultat tyder också på att rutinerna för att göra patienterna delaktiga i valet av behandling och kring vad behandlingens huvudfokus ska vara skulle kunna förbättras.

ACKNOWLEDGEMENTS

First of all, I would especially like to thank the participants in this study for taking time to share your thoughts and experiences. I feel honoured to have had the opportunity to meet all of you – you have inspired me in my work and you have made me grow, both as a future doctor and as a person. I would also like to thank Vania Ranjbar and Henry Ascher for your pedagogical and excellent supervision and never-ending patience and support, and the Refugee Children’s Team for inspiring me and taking time to introduce me to your work. In particular, I would like to thank Ulrika Hedberg for devoted help and assistance throughout the study. I would also like to thank Hannes Norblad for taking time to tell me about his master’s thesis focusing on unaccompanied minors as patients at the Refugee Children’s Team, and the University of Gothenburg’s Department of Philosophy, Linguistics and Theory of Science for providing recording equipment and finally Angered Hospital for providing cinema gift vouchers for the participants.

REFERENCES

1. UNHCR. UNHCR Global Trends 2013. Geneva: UNHCR United Nations High Commissioner for Refugees; 2014.
2. Utlänningslag (2005:716) (SFS 2005:716). Stockholm: Justitiedepartementet.
3. UNHCR. Convention and Protocol Relating to the Status of Refugees. Geneva: UNHCR, Media Relations and Public Information Service; 2007.
4. Utlänningslag (2005:716) (SFS 2005:716), 1 kap. Lagens innehåll, vissa definitioner och allmänna bestämmelser. Stockholm: Justitiedepartementet.
5. Migrationsverket. Inkomna ansökningar om asyl helåret 2009. 2010.
6. Migrationsverket. Applications for asylum received, 2013. Norrköping: 2014.
7. Migrationsverket. Verksamhets- och kostnadsprognos Juli 2014. Norrköping: 2014 24 juli. Report No.
8. Socialstyrelsen. Social rapport 2010. Västerås: 2010.
9. Ehntholt KA, Yule W. Practitioner review: assessment and treatment of refugee children and adolescents who have experienced war-related trauma. *Journal of child psychology and psychiatry, and allied disciplines*. 2006 Dec;47(12):1197-210. PubMed PMID: 17176375. Epub 2006/12/21. eng.
10. Fazel M, Wheeler J, Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet*. 2005 Apr 9-15;365(9467):1309-14. PubMed PMID: 15823380. Epub 2005/04/13. eng.
11. Fazel M, Reed RV, Panter-Brick C, Stein A. Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *Lancet*. 2012 Jan 21;379(9812):266-82. PubMed PMID: 21835459. Epub 2011/08/13. eng.
12. Ascher H, Mellander L. Asylsökande barns tankar om hälsa. In: Andersson H, Ascher H, Eastmond M, Björnberg U, editors. *Mellan det förflutna och framtiden: Asylsökande barns välfärd, hälsa och välbefinnande*. Göteborg: Centrum för Europaforskning, Göteborgs universitet (CERGU); 2010.
13. Hälso- och sjukvårdslag (SFS 1982:763). Stockholm: Socialdepartementet.
14. Lag (2008:344) om hälso- och sjukvård åt asylsökande m. fl. (SFS 2008:344). Stockholm: Justitiedepartementet.
15. Lag (2013:407) om hälso- och sjukvård till vissa utlänningar som vistas i Sverige utan nödvändiga tillstånd (SFS 2013:407). Stockholm: Socialdepartementet.
16. Socialdepartementet. Konventionen om barnets rättigheter - med strategi för att stärka barnets rättigheter i Sverige. Stockholm: 2014.
17. United Nations. Convention on the Rights of the Child: Office of the High Commissioner for Human Rights; 1989 [cited 2014 23th of August]. Available from: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>.
18. Skollag (2010:800), kap. 29 (SFS 2010:800). Stockholm: Utbildningsdepartementet.
19. Socialtjänstlag (2001:453) (SFS 2001:453). Stockholm: Socialdepartementet.
20. Migrationsverket. Financial Support - Swedish Migration Board: Migrationsverket; [cited 2014 4th of December]. Available from: <http://www.migrationsverket.se/English/Private-individuals/Protection-and-asylum-in-Sweden/Adults-seeking-asylum/Financial-Support.html>.
21. Flyktingbarnteamet. Verksamhetsrapport Flyktingbarnteamet 2013. Göteborg: 2014.

22. Norblad H. Ensamkommande flyktingbarns möte med Flyktingbarnteamet i Göteborg - En journalstudie. Gothenburg: University of Gothenburg; 2014.
23. Bean T, Derluyn I, Eurelings-Bontekoe E, Broekaert E, Spinhoven P. Comparing psychological distress, traumatic stress reactions, and experiences of unaccompanied refugee minors with experiences of adolescents accompanied by parents. *The Journal of nervous and mental disease*. 2007 Apr;195(4):288-97. PubMed PMID: 17435478. Epub 2007/04/17. eng.
24. Eide K, Hjern A. Unaccompanied refugee children--vulnerability and agency. *Acta paediatrica (Oslo, Norway : 1992)*. 2013 Jul;102(7):666-8. PubMed PMID: 23560773. Epub 2013/04/09. eng.
25. Wernesjö U. Unaccompanied asylum-seeking children: Whose perspective? *Childhood*. 2012;19(4):495-507.
26. Kvale S. *Doing interviews*. London: Sage; 2008.
27. Ritchie J, Lewis J, Lewis PSPJ, Nicholls CMN, Ormston R. *Qualitative Research Practice: A Guide for Social Science Students and Researchers*: SAGE Publications; 2013.
28. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 2006;3(2):77-101.
29. Fiske ST. Institutional Review Boards: From Bane to Boon. *Perspectives on psychological science : a journal of the Association for Psychological Science*. 2009 Jan;4(1):30-1. PubMed PMID: 24115966. Pubmed Central PMCID: PMC3792564. Epub 2009/01/01. Eng.
30. Ahn S, Fedewa AL. A meta-analysis of the relationship between children's physical activity and mental health. *Journal of pediatric psychology*. 2011 May;36(4):385-97. PubMed PMID: 21227908. Epub 2011/01/14. eng.
31. Wade J, Mitchell F, Baylis G. *Unaccompanied asylum seeking children: The response of social work services*: BAAF London; 2005.

APPENDIX A

Intervju-underlag

1. Vad tycker du om Flyktingbarnteamet?
 - a. Vad tänker du på först när du tänker på Flyktingbarnteamet?
 - b. Kände du dig välkommen till Flyktingbarnteamet?
 - c. Kändes det tryggt att komma till Flyktingbarnteamet?
2. Vilken typ/vilka typer av behandling fick du från Flyktingbarnteamet?
 - a. För vilka besvär fick du behandling hos Flyktingbarnteamet?
 - b. Hur har du upplevt behandlingen du fått?
 - c. Har behandlingen varit till hjälp för dig?
 - d. Om ja, på vilket sätt?
 - e. Om nej, varför inte?
3. Hur tycker du att du blivit bemött av Flyktingbarnteamet?
 - a. Tycker du att du har blivit lyssnad på av dem du mött på Flyktingbarnteamet?
 - b. Har dina tankar och åsikter tagits på allvar?
 - c. Känner du att du kunnat påverka din behandling?
4. Vad har varit bra med att gå hos Flyktingbarnteamet?
 - a. Vad har varit det viktigaste för dig med att gå hos Flyktingbarnteamet?
5. Är det något som inte varit bra med behandlingen du fått av Flyktingbarnteamet?
 - a. Om ja, på vilket sätt?
 - b. Är det något som du tycker fattas i behandlingen som Flyktingbarnteamet har gett dig?
6. Har du förslag på hur Flyktingbarnteamet skulle kunna bli bättre på att hjälpa och stötta barn och unga i samma situation som den du varit i?
7. Tror du att hjälpen du fått av Flyktingbarnteamet påverkat hur du mår idag?
 - a. Om ja, på vilket sätt?
 - b. Om nej, varför inte?
8. Vad är viktigt för att man ska må bra när man kommer ny till ett land som du har gjort?
 - a. Om du skulle ge hjälp åt barn och unga i samma situation som den du varit i, hur skulle du göra då?
 - b. Vilket tycker du är det viktigaste att få hjälp och stöttning med när en kommer som flyktingbarn till Sverige?
 - c. Har du fått den hjälpen?
9. Hur kändes den här pratstunden?

APPENDIX B

Interview guide

1. What do you think about the Refugee Children's Team?
 - a. What is the first thing you think of when you think of the Refugee Children's Team?
 - b. Did you feel welcome to the Refugee Children's Team?
 - c. Did it feel safe to go to the Refugee Children's Team?
2. What sort/sorts of treatment did you get from the Refugee Children's Team?
 - a. For what kind of problems did you get treatment at the Refugee Children's Team?
 - b. How is your experience of the treatment you have got?
 - c. Has the treatment been helpful for you?
 - d. If yes, in what way?
 - e. If no, why not?
3. How do you think you have been treated by the Refugee Children's Team?
 - a. Do you think that you have been listened to by those you have met at the Refugee Children's Team?
 - b. Have your thoughts and opinions been taken seriously?
 - c. Do you feel that you have been able to influence your treatment?
4. What have been good with going to the Refugee Children's Team?
 - a. What have been the most important for you with going to the Refugee Children's Team?
5. Is there anything that has not been good with the treatment you have got from the Refugee Children's Team?
 - a. If yes, in what way?
 - b. Is there anything that you think is missing in the treatment that the Refugee Children's Team has given to you?
6. Do you have suggestions on how the Refugee Children's Team could be better at helping and supporting children and adolescents in the same situation as you have been in?
7. Do you think the help you have got from the Refugee Children's Team have affected how you feel today?
 - a. If yes, in what way?
 - b. If no, why not?
8. What is important for feeling good when arriving in a new country as you have done?
 - a. If you would give help to children and adolescents in the same situation as the one you have been in, how would you do then?
 - b. What do you think is the most important thing to get help and support with when one arrives as a refugee child in Sweden?
 - c. Have you got that kind of help?

9. How do you feel about this interview/chat?