Comments on the Swedish Migration Board report "Kartläggning av barn med uppgivenhetssymtom" [Survey of children with symptoms of apathy] from March 2011

Part 1

August 2011

By
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Etikkommissionen i Sverige
- nätverket för mänskliga rättigheter och asylrätten.
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- nätverket för mänskliga rättigheter och asylrätten

The Ethics Commission in Sweden network is a religious and party politically independent social movement aiming to bare witness to and protest against violations of human rights for asylum seekers and other children and adults in need of protection who are living in Sweden. For more information in Swedish see:
http://www.etikkommissionenisverige.se/

This is a report to the Etikkommissionen i Sverige [the Ethics Commission in Sweden]. The report is compiled and authored in Swedish and English by Karin Johansson Blight, independent researcher, during July-August 2011. The work was conducted on a voluntary basis.

Introduction
The report provides comments to the report presented by the Swedish Migration Board in March 2011 with the titled "Kartläggning av barn med uppgivenhetssymtom" [Survey of children with symptoms of apathy][1]. The aim with the present report is to provide in-depth understanding of the latest data and reasoning around children who are suffering from symptoms of apathy and who are registered within the Swedish migration reception system.

Outline
After an introduction the present report presents a background outlining the content and structure of the Swedish Migration Board (SMB) report. On the basis of this information, the content of the SMB report is reflected upon and an interpretation is made in relation to the frequencies presented and concepts used in the SMB report. This is followed by suggestions on how the SMB report could be improved as well as a presentation of what questions Part 2 of the commentary to the SMB report is intended to cover. Finally, three supplements are attached to this report.

Knowledge about children with reduced capacity/disability in the Swedish reception system
As shown in a previous study [2], the knowledge amongst Swedish authorities about how many children who are suffering from symptoms of apathy in Sweden is limited. However, this information, i.e. knowledge about children who are living with reduced capacity/disability due to poor mental and physical health within the Swedish reception system, is important as such knowledge could strengthen children’s and their families human rights and possibilities for an improved health- and living situation. Sweden has through international agreements (universal and international conventions) such as the Convention on the Rights of the Child (1989) [3], Convention on the Rights of Persons with Disabilities (2006) [4], and the United Nations Universal Declaration of Human Rights (1948) [5] undertaken to ensure that human rights are observed in practice. The initiative to present the number of children with severe disabilities or at risk for developing severe disabilities due to mental and physical ill-health known to the Swedish Migration Board is hence, based on a human rights perspective, considered to be positive. The report includes much information that is interesting for the understanding of children with symptoms of apathy; one example is that the report includes unaccompanied minors and children without parents.

Background
The Swedish Migration Board (SMB) report
For an outline and content of the SMB report see Box 1 (below). The following assumptions are made on the basis of the outline of the SMB report (Box 1):
- The report can be said to be made up of three parts: one part consists of a summary table (frequency table), one contains information about methods/questions, and a third part that presents the case reports provided to the Swedish Migration Board by the reception units (27 across Sweden).
- The purpose of the frequency table is to summarise the case reports.
The following important information can be understood from the content of the SMB report (for summary see Box 1): In the present context,
- “Diagnosis” refers to Grade 2-3 categories of symptoms of apathy,
- “At risk” refers to the Grade 1 category of symptoms of apathy.
The Swedish Migration Board report "Kartläggning av barn med uppgivenhetssymtom" is authored by Per Sörensen and was released in March 2011. The report consists of 17 pages in total.

**Frequency table**

Page 1 presents a summary frequency table. The table is a simple summary table with the title "Barn med uppgivenhetssymtom i mottagningsystemet mars 2011" [1][Children with symptoms of apathy in the reception system March 2011] and it contain a list of reception units (n=27) and in relation to the reception units the number of children with a "diagnosis" of apathy\(^a\), and the number of children “at risk” and date (day/month/year).

Below the table total numbers of children with “diagnosis” and “at risk” in the periods March 2011, November 2010 and June 2010 are presented. This is followed by a brief paragraph, which explains that “diagnosis” refers to Grade 2 and 3. It also explains that Grade 3 is the category that, according to the head of the mobile asylum team in Stockholm, most correctly defines symptoms of apathy.

On page 2 of the SMB report the instructions given by the SMB to the reception units is presented (for content, see Attachment 1 of the present Ethics Commission report). Included on page 2 of the SMB report is also an explanation “at risk” refers to Grade 1. On page 3 in the report, further questions posed to the reception units are also presented (for content, see appendix 2 of the present Ethics Commission report).

**Reception units’ [mottagningsenheternas] case presentations**

On page 3-17 the reception units’ case descriptions are presented covering the number of children known by the reception units who are presenting with symptoms of apathy. The case presentations also contain answers to some further questions posed to the reception units by the Swedish Migration Board.

\(^a\) Other terms often used is “pervasive refusal syndrome” or “devitalised state”.

**Total number of children with symptoms of apathy mentioned in the SMB report**

The total number of children with symptoms of apathy Grade 1-3 included in the report is 75 children\(^1\).

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\(^1\) In the frequency table (page 1 [1]) a total of 75 children with symptoms of apathy are presented. In the case presentations a total of 76 children are mentioned (pages 3-17, [1]), of these 74 children can be categorised to be at risk of apathy, i.e. can be categorised to suffer from Grade 1 level of apathy, or are presenting with Grade 2-3 symptoms of apathy. Two of the children mentioned are over 18 years of age, and one of these has a psychiatric diagnosis and belongs to the same family as a child categorised as being at risk (Göteborg). If this child is included, the total number of children with symptoms of apathy Grade 1-3 = 75 children. Finally, one more person is mentioned as a child in a family in the report (i.e. total n = 76 children), however, this child is over 18, and do not present any symptoms, and is hence not included in the total number of children with symptoms of apathy (Grade 1-3). For details see table 3, appendix 3 of the present report.
**Differences in numbers presented in the frequency table and in the case presentations with regards to the number of children per each Grade**

It is important to note that the reporting of numbers in the case presentations (page 3-17 [1]) and the frequency table (page 1, [1]) is as, as shown in Table 1 below, the opposite.

Closer examination shows that the figures in the frequency table differ from those presented in the case descriptions on ten occasions (for a detailed description about the noted differences see appendix 3 of this report).

The total number of children with symptoms of apathy Grade 2-3 (diagnosis) is significantly higher in the reception units’ case presentations than that which is presented in the summary frequency table (see Table 1 below).

As the tables below show the reception units’ case presentations (pages 3-17, [1]) report 31 children with Grade 3 and 14 children with Grade 2 (Table 2), i.e. *a total of 45 children with Grade 2-3 (diagnosis)* (Table 1).

Expressed as a percentage, 60.0% of all the 75 children mentioned in the Swedish Migration Board report are said to suffer from symptoms of apathy Grade 2-3 (diagnosis).

There are in other words, thirteen more children with "diagnostic" (Grade 2-3) mentioned in the reception units case presentations (page 3-17 [1]) than in the frequency table in the SMB report (page 1, [1]).

**Table 1** The total number of children in relation to Grade of symptoms of apathy described in the SMB report in the frequency table (Page 1) and in the case presentations (pages 3-17) [1]

<table>
<thead>
<tr>
<th>Grade</th>
<th>The number of children mentioned in the frequency table</th>
<th>The number of children mentioned in the case presentations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 2-3</td>
<td>32 (42.7)</td>
<td>45 (60.0)</td>
</tr>
<tr>
<td>Grade 1</td>
<td>43 (57.3)</td>
<td>30 (40.0)</td>
</tr>
<tr>
<td>Total</td>
<td>75 (100)</td>
<td>75 (100)</td>
</tr>
</tbody>
</table>

**Table 2** The total number of children with symptoms of apathy per each Grade 1-3 as described in the reception units case presentations (page 3-17 [1])

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number (percent, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 1</td>
<td>30 (40.0)</td>
</tr>
<tr>
<td>Grade 2</td>
<td>14 (18.7)</td>
</tr>
<tr>
<td>Grade 3</td>
<td>31 (41.3)</td>
</tr>
<tr>
<td>Total</td>
<td>75 (100)</td>
</tr>
</tbody>
</table>
Why is it important to pay attention to reporting errors?

Frequencies and statistics can easily be wrong. Causes of errors in reporting may vary; it may be due to honest mistakes and time constraints impacting on the ability to check figures, general negligence or deliberate misdirection. In relation to the SMB report, it is important to pay attention to the ten occasions when discrepancies have occurred as:

1) Each number represents a child in an extremely exposed life situation. It is hence important to earnestly recognise each number presented.

2) It is assumed that the purpose of the SMB report like other survey reports is to make available statistics to the media and the public so that the public can gain a true understanding of the situation. Frequency tables are typically used to summarise a wide range of information so that it becomes easy for the reader to get an accessible overview. Frequency tables should for this reason be possible to read without necessarily having to read the entire report. Errors in frequency reporting increases the risk of confusion about how many children in the system are at risk of developing severe disabilities/are living with severe disabilities. Consequently, the public is deprived of an accurate understanding of the situation.

3) Accurate reporting of the information, which the authority has access to is important for accountability, for the authority to be a reliable operator and for maintaining a good reputation within the international community. It is not only about honesty, but also about responsibility and children's safety and protection.
   a) The ability to guarantee a secure system and prevent vulnerability and exploitation of children cannot be made if the Swedish Migration Board does not correctly convey the knowledge the authority holds in respect to the number of children with disabilities (such as children with symptoms of apathy). The reason for this is because no one will know how many were known in the system at the time of the survey/s. A query is also whether or not all children known to the Swedish Migration Board are included in the report. The Ethics Commission has, for example, knowledge about an existing case involving a child who is known to the Swedish Migration Board who is showing symptoms of apathy but does not appear to be included in the report. Questions arise about the original number of children who have been expelled/deported and what has happened to them after expulsion/deportation? It is, hence, good to highlight the level of awareness of possible shortcomings in information reporting.
   b) The ability to assess change over time will be prevented if the frequencies summarised are not accurate, and thus can not be used to explore important questions such as if there are more or fewer children in the system from one year to another, if the children become better or worse with or without treatment, etc.
   c) Presentation of incorrect figures threatens to undermine confidence in statistics previously produced by the Swedish Migration Board in this area, and potentially also other statistical information produced by the authority.

4) Accurate reporting is also important for practical reasoning, which is less based on emotionally politically motivated actions, and more specifically linked to the health and well-being of children under international conventions (such as the conventions on human rights). If one does not know what can be considered the basis for the argument, it becomes difficult to reason around practical implications.
Assessment of disability

The diagnosis construct
In the frequency table of the Swedish Migration Board report the concept “diagnosis” is used (part 1 [1]). On page 2 [1] the report states that "diagnosis" refers to a target group definition:

Assessment of disability and the categorisation of children with symptoms of apathy into three groups shall not be understood as a diagnostic instrument but as a basic prerequisite to enhance the visibility of these children’s psychiatric and medical care needs, in other words a definition of a target group (page 2 [1]). [Original citation: "Funktionsnivåbedömningen och uppdelningen av barn med uppgivenhetssymtom i 3 grupper skall inte förstås som ett diagnostiskt instrument, utan som en grundläggande förutsättning för att synliggöra dessa barns psykiatriska och medicinska vårdbehov, med andra ord en målgruppsdefinition" (sidan 2 [1]).]

The concept “diagnosis” (in this context) risks misleading the reader as there usually is a doctor who makes diagnoses of disease and/or disabilities. By using the diagnostic concept in the frequency table (Page 1) [1] there is a risk that the reader of the report might be led to believe that doctors have been involved in deciding the diagnosis of the children, although this is not the case. The use of the term "diagnostic" also raises a paradox: it seems like medical terminology (symptom/syndrome, diagnosis and epidemic) has over time been used by the authority and the Government while at the same time medicine and health care have been prevented from fully engaging with ill health development amongst children in the migration process. An example is that the knowledge base derived from the health care system in terms of physical and mental health among children has not sufficiently been taken into account [6].

Grading
It is not clear on the basis of the report who has categorized the children according to the grades. However, this information would be appropriate since assessment may vary depending on the profession involved in the grading. There are different ways of grading symptoms of apathy and disability [2]. In the Swedish Migration Board report [1] three grades are used, which has been developed (and is used by?) the Stockholm County Council. Another common degree classification is the one recommended by the National Board of Health and Welfare, which consist of two grades (Grade 1 and 2) [2]. Is this the reason that the “diagnosis" refers to Grade 2 and 3?

A stricter interpretation of grade
The Swedish Migration Board states that according to stricter definition apathy refers only to grade 3. In connection to this statement, it is also states that when applying this stricter interpretation, there are 18 asylum seeking children with Grade 3 (Page 1, [1]). The question is however whether this means that out of all asylum-seeking children, 18 children suffer with symptoms of apathy Grade 3? If so, how many is the total number of asylum seeking children? A certain ambiguity arises, since both the frequency table and case presentations includes children at different stages of the asylum process; for example it includes children with residence permits, children who have been dismissed from the Migration Court, and children who are under deportation orders.
One possibility is that the more strict interpretation includes the children (asylum seekers and other children) referred to in the Swedish Migration Board report and who are receiving enteral feeding – i.e. 13 children. Two more children are mentioned as being in need of help from their parents in order to eat. Together, this totals 15 children. The problem is however that nothing in the Swedish Migration Board report suggests that the reception units have been asked the question whether or not the children concerned are receiving enteral feeding and overall the reporting of symptoms is generally weak. In other words, it is not possible on the basis of the report to know whether or not the fact that enteral feeding is provided, is a matter reported by the reception units in relation to those children receiving this help. The only matter that can be understood from the report is that at least 13 children are receiving enteral feeding and at least 2 children need other assistance with feeding.

Suggestions to the Swedish Migration Board with regard reporting of information concerning children with symptoms of apathy
To improve clarity;
- Avoid medical terminology and instead, use the names of the categories that are considered. Avoid using the concept of diagnosis, as a medical psychiatric diagnosis is absent.
- Include in the report/future reports regarding children with symptoms of apathy, what the purpose of the report/s is/are, what should the information be used for and in what ways will the children benefit from the grading? Also, where, according to the Swedish Migration Board’s, lies the threshold for §5.6 in first instance (or § 12.18 " particularly distressing circumstances") regarding acceptance or rejections with regards to devitalised children (especially with regards to impediments to enforcement); is it only the children who are fed through enteral feeding who receive inhibition and eventually permanent residence?
- Revise the frequency table and state the correct frequencies
- Provide more detail on how data collection was made. The present report contains too many loopholes about data collection and the process around the description of the frequencies. Important questions are how has the knowledge been gathered and summarised? What is being done to reduce error reporting? Are in fact all children with symptoms of apathy, known to the Swedish Migration Board, included?
- Present in more detail what is included in a "stricter" interpretation of the number of children with Grade 3 (the number mentioned in the report on page 1 [1] is 18 children- what is the basis for this number? From where does the number 18 children derive?)
- In some cases, the information about the children is weak and would benefit from follow-up. It would also be appropriate to include any plans made with regards to follow-up and clarifications in relation to the lack of information. It is also useful to report why the number is 0 in some reception units, zero is also interesting.
Part 2 of the Comments to the Swedish Migration Board report "Kartläggning av barn med uppgivenhetssymtom" [Survey of children with symptoms of apathy] [1]: Part 2 of this report is due to be completed and reported to the Ethics Commission in September 2011. Part 2 will contain a summary and discussion in relation to:

- Prevalence (overall and per grade 1-3) in relation to the total number of children in the reception system.
- Summary of the number of children that according to the reception units’ case presentations in the Swedish Migration Board report, do not go to school, reasons why children do not attend school and what grading is attributed to children who are not attending school.
- Summary of information about the parents’ situation (reported number of help-seeking behaviour and poor mental health) in relation to children’s Grade (1-3). What age are the children whose parents are reported to have poor mental/health?
- In what ways is collaboration between different organisations reported? When is collaboration reported to be working well and when is it not? What different types of collaborative constellations are reported?
- What specific symptoms are described (and what are the frequencies) of the reception units in general and in relation to Grade 1, 2 and 3?
- How many children are mentioned in the report in relation to the different stages of the migration process: how many have received residence permits? How many have had their cases examined by the Migration Court [Migrationsdomstolen] and how many are about to be deported/rejected?

References


2 Swedish definition: "synnerligen ömmande omständigheter", English translation found on Swedish Migration Board website: http://www.migrationsverket.se/info/774_en.html. Updated: 2009-11-20 Accessed: 2011-09-12. The website further states: "Particularly distressing circumstances may be a basis for a residence permit in Sweden. This involves situations where circumstances are such that the overall situation seems to be particularly distressing. For example, persons suffering from a life-threatening disease for which they cannot be treated in their country of origin. The particularly distressing circumstances basis for a permit shall be applied in exceptional cases in accordance with the law."
Appendix 1 Instructions for the units who will provide information

Instructions for the units who will provide information to aid in the assessment of whether a child is at risk [of developing symptoms of apathy], the proposed grading, developed within Stockholm County Council in relation to the introduction of a new care structure for children with symptoms of apathy in 2005. Grade 1 includes children who are at risk for developing symptoms of apathy but who are not yet in need of somatic interventions within the health care structure. Degrees of resignation can be described as follows:

Grade 1. Depressive state
Asylum seeking children, who exhibit clear signs of depression, constitute a group at risk of entering into a devitalised state. These children are passive, show little interest in other people, and movement is slow or characterised by unrest. Appetite is poor, but the child can eat and drink sufficient amounts. The child is also caring to some extent about their daily routines, however, does so with not interest or engagement.

Grade 2. On the way to apathy/lethargy
A child who is coming into a devitalised state makes limited contact, can nod in response or reply with a few number of words, and reacts if possible to single events. Mobility is reduced, and the child must be asked to move, or to get help or support to movement within or outside the home. Appetite is limited; parents have to encourage the child to eat since the child itself displays little interest in food or cannot feel hunger. The daily routine is maintained with the help of parents or through encouragement by them.

Grade 3. State of apathy/lethargy
The state means that the child is unable to contact, eyes are shut or the child look in the floor and displays no or very limited interest in the outside world. While mobility is very limited, the child is predominantly bed ridden and must have help moving. Food intake is via enteral feeding or the parents must feed the child. The child is, furthermore, experiencing difficulties or finds it almost impossible to continue with daily routines such as maintaining hygiene and getting dressed; the child may be incontinent and is often unaware of such signals, and cannot get dressed independently.

Functional level assessment and the division of children with pervasive refusal syndrome into 3 groups shall not be construed as a diagnostic instrument, but as a fundamental prerequisite to give visibility to these children's psychiatric and medical care, in other words; diagnosis is in other words a definition of a target group. The child psychiatric diagnosis can still take the form of, for example, depression, PTSD or PRS. Another extremely important function for functional level assessment has been that it also enabled a common language between the different clinical disciplines.

From reference:
Appendix 2 Questions to the reception units

Further questions the reception units were asked to answer:
Is the child participating in preschool/school?
If the answer is no:
Has the child never participated in preschool/school or has it stopped for health reasons?
Are the parents' help-seeking?
Are there question marks about the parents' abilities to provide care for their child?
Has a referral been made to social service?
Is there an on-going investigation/intervention by social services/BUP [BUP- child- and adolescent psychiatric services]?
How is the collaboration between the Swedish Migration Board/social services/County Council BUP?

From reference:
Appendix 3. Detailed description of discrepancies between the frequency table and reception units’ case presentation and other comments

The information in Appendix 3 derives from the Swedish Migration Board report [1] and is a comparison between the frequency table (page 1) and the case presentations (pages 3-17) [1]. The information is presented in detail below. Only cases where a difference in reporting has been observed between the frequency table and case presentations are presented in the text. All representations (including where the reporting matches) are included in the detailed frequency table at the end of Appendix 3 (see Table 3- dark blue background indicate observed differences in reporting). Other comments included in Appendix 3 concerns occasions where information in case descriptions is missing and where a definition of grading has been made on the basis of the case presentations.

Reception units, differences between frequency table and case presentations and other comments

Alvesta
Frequency table: Two children (Grade 2-3) and three children (Grade 1).
Case presentation: Two children (Grade 3), three children (Grade 2) and no child (Grade 1).
Conclusion: the frequency table and case presentation do not match.

Borås
Frequency table: Two children (Grade 2-3) and one child (Grade 1).
Case presentation: Reading the case presentation in relation to what is given as guidance on grading symptoms of apathy it is likely that the frequencies in the table in the Swedish Migration Board report (page 1, [1]) is not correct. Two children are in school while one child has never started school due to clear signs of apathy. It is thus likely that the school children may show signs and be at risk, i.e. n= 2 (Grade 1). It is possible that the child who does not attend school shows symptoms that should more correctly be categorised as grade 2. It is possible that the child should more correctly be categorised as suffering from symptoms within the remit of Grade 2 rather than 3; however, as the reception units are reporting that the child on arrival showed “clear symptoms” (page 4, [1]), this child has been categorised within the remit of Grade 3 until more information about the child has been gathered so that a sufficient understanding of the child’s situation can be reached.
Conclusion: the frequency table and case presentation do not match.

Göteborg
Frequency table: no children (Grade 2-3) and six children (Grade 1).
Case presentation: no children (Grade 3), no children (Grade 2) and eight children (Grade 1).
Note: the case presentations includes three more children, one of these children appear to most appropriately be included within the grade frequency 1; he is below 18 years of age, he suffers from incontinence and poor mental health and is in need of support to be able to attend school. Two more children are mentioned in the case presentations but they are both above 18 years of age. Nevertheless, one of them is a 19-year old who suffers from chronic psychosis.
For this reason as well as the fact that the child belongs to a family where a younger sibling has been identified by the reception unit personnel to be at risk, this person has also been included as to be at risk of apathy (grade 1).

**Conclusion: the frequency table and case presentation do not match.**

**Högsby**

Frequency table: one child (Grade 2-3) and four children (Grade 1).
Case presentation: two children (Grade 3), two children (Grade 2) and one child (Grade 1).
Note: one additional child is mentioned in notes in relation to a boy with Grade 3: [the reception unit reports:] *there is also grave concern about the younger brother* (page 7, [1]). However, there is no mention of what type of concerns exist. Hence, it appears appropriate to include this child within the remit of Grade 1 (at risk) until more information about the child’s health status is available.

**Conclusion: the frequency table and case presentation do not match.**

**Kristianstad/Karlskrona**

Frequency table: three children (Grade 2-3) and three children (Grade 1).
Case presentation: three children (Grade 3), three children (Grade 2) and no child (Grade 1).

**Conclusion: the frequency table and case presentation do not match.**

**Skövde**

Frequency table: one child (Grade 2-3) and five children (Grade 1).
Case presentation: one child (Grade 3), two (Grade 2) and five children (Grade 1).
Note: three children are categorised by the reception unit as suffering from symptoms within the remit of Grade 2-3. As regards children who have been categorised with Grade 1 level symptoms, on two occasions (page 11 [1]) two children belong to the same families. Name, age and gender, and country of the children are presented before the Grade is presented (Grade 1 in both contexts). It is slightly difficult to assess the information since the Grades are not reported per each child; however, on the basis of how the sections are structured, it seems as if the reception units are reporting that two children in both instances (i.e. a total of four children) are considered at risk.

**Conclusion: frequency table and case presentation do not match.**

**Norrköping**

Frequency table: one child (Grade 2-3) and no children (Grade 1).
Case presentation: one child (Grade 3), no child (Grade 2) and no child (Grade 1).
Note: there is no information available in the case presentation that describes the health status of the child. But the child has left school and the family has been cared for in a family treatment facility since February 2011. Thus the child is assumed to be within the framework of the Grade 3 until further research has been done.

**The frequency table and case presentation correspond but grading has been specified.**

**Umeå**

Note: information from Umeå is missing in the case presentations. The reason as to why information from Umeå has not been included is also missing. Was no information provided by the reception unit?
Or, are there no children with symptoms of apathy in this catchment area? The figures (0) described in the frequency table, can due to the nature of the lack of information not be verified.

*Information is missing in the case presentation.*

**Solna AM1**
Frequency table: four children (Grade 2-3) and one child (Grade 1).
Case presentation: four children (Grade 3), no children (Grade 2) and two children (Grade 1).
Note: one child is mentioned in the frequency table as suffering from symptoms of Grade 1. However, one more child is mentioned in the text provided by Solna AM1. Solna AM1 indicates that this child was born in 2005 and while the child do not present with any symptoms it is monitored due to the family situation. In other words, Solna AM1 is treating the child as if it is at risk and it is probably best to reflect this in the frequency table. Hence, the child is therefore added to the category “at risk” (Grade 1).

*Conclusion: frequency table and case presentation do not match.*

**Solna AM4**
Note: information from Solna AM4 is missing in the case presentations. The reason as to why information from Solna AM4 has not been included is not given. Was no information provided by the reception unit? Or are there no children with symptoms of apathy in the catchment area? The figures (0) described in the frequency table, due to the nature of the lack of information cannot be verified.

*Information is missing in the case presentation.*

**Söderhamn**
Frequency table: no children (Grade 2-3) and no children (Grade 1)
Case presentation: one child (Grade 3), no children (Grade 2) and no children (Grade 1).
Note: no children are reported in the frequency table. In the case presentation, however, one child is reported within the remit of Grade 3.

*Conclusion: frequency table and case presentation do not match.*

**Uppvidinge**
Frequency table: three children (Grade 2-3) and three children (Grade 1).
Case presentation: three children (Grade 3), three children (Grade 2) and no children (Grade 1).
Note: three children categorised as presenting with symptoms within the remit of Grade 1, however, the case presentations clearly mention three children with Grade 2 (no children are mentioned with Grade 1)

*Conclusion: frequency table and case presentation do not match.*

**Örebro**
Frequency table: one child (Grade 2-3) and eight children (Grade 1).
Case presentation: no child (Grade 3), one child (Grade 2) and one child (Grade 1).
Note: in the frequency table one child is mentioned with Grade 2-3 and eight children with Grade 1. However, the case presentation only mentions two children, one child with Grade 1 symptoms and one child with Grade 2.

*Conclusion: frequency table and case presentation do not match.*
Table 3 Frequencies (per Grade 1-3) in the Swedish Migration Board’s summary frequency table and reception units’ case presentations

<table>
<thead>
<tr>
<th>Reception Units</th>
<th>Diagnosis (Grade 2+3)</th>
<th>At risk (Grade 1)</th>
<th>Frequencies in case presentations</th>
<th>Number of children per Grade (G) 1-3</th>
<th>Total number of children in the case presentations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Grad 2+3</td>
<td>Grad 1</td>
<td>G1</td>
</tr>
<tr>
<td>1. Alvesta</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2. Boden</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3. Borås</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
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<tr>
<td>4. Flen</td>
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<td>5. Göteborg</td>
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<td>Percentage (%) of 75 children</td>
<td>42.7</td>
<td>57.3</td>
<td>60.0</td>
<td>40.0</td>
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</table>

*In brief: the number of 76 children in the right column contains the total number of children mentioned in the case descriptions [1]. One of these children is 16 years of age, is suffering from poor mental health, is incontinent and needs help in order to attend school. This child can thus be considered to be at risk of symptoms of apathy (this child has therefore been included in the Grade 1 frequency). Two more children from the same family are 19 years of age, one of them has a chronic mental illness, and is for this reason included within the remit of Grade 1 (at risk). The other child has no symptoms of disease or symptoms (page 5-6, [1]) and is therefore not included in rate frequencies. The number of 76 children in the right column also contains one child mentioned in the case presentations (in Högby) as of concern. However, as no symptoms or mention is named about what type of concerns there are (Page 6-7, [1]), the child is included within the remit of Grade 1. *The total number of children is 75 since one child in Göteborg is not included in the table.