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Rehabilitation and social reintegration of asylum-seeking children affected by war and armed conflict

Milfrid Tonheim
Ilse Derluyn
Ellen Vea Rosnes
Dima Zito

with
Marina Rota
Audhild Steinnes

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Senter for interkulturell kommunikasjon
Centre for Intercultural Communication
Centre pour la Communication Interculturelle

Senter for Interkulturell Kommunikasjon

Misjonsmarka 12, 4024 Stavanger, Norway

P.O. Box 226, 4001 Stavanger, Norway

Phone (+47) 51 51 62 74 / E-mail: sik@sik.no
Homepage: http://www.sik.no

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ISSN:	1500-1474	***Authors :***	Milfrid Tonheim, Ilse Derluyn, Ellen Vea Rosnes and Dima Zito. With Marina Rota and Audhild Steinnes.
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Abstract

Commissioned by the Norwegian Directorate of Immigration (UDI) and the Norwegian Directorate of Health, this study focuses on the realization of the right to rehabilitation and social reintegration assistance to asylum-seeking children who have been victims of, participated in or witnessed acts of war. The report describes good practices on psychosocial support from Denmark, Sweden and Luxembourg and presents lessons learned from rehabilitation and reintegration programmes for war-affected children by international organizations. In addition, the Norwegian context is also taken into account through examples of psychosocial support on different levels in the Norwegian society. The project is based on a desk study and qualitative interviews. The empirical data material consists of 16 interviews with practitioners, four with national experts in the case countries and one expert interview in Norway. Interviews were also conducted with five war-affected youth, five parents of war-affected asylum-seeking children and three foster parents for unaccompanied minors.

The report argues that rehabilitation interventions and social re/integration measures need to take into account both protective factors and risk factors. Examples of protective factors are structured activities within arenas such as school and kindergarten, a well-established and stable accommodation, participation in regular recreational activities, supportive and emotionally available parents, supportive adults outside the family and peer relationships, not least through establishing new social networks with native peers. Appropriate cross-culturally sensitive therapeutic care need to be provided to those children, or those parents, who are traumatized or suffer from other types of mental problems related to war experiences.

The report presents recommendations to Norwegian authorities on how to improve identification, rehabilitation and social re/integration of war-affected asylum-seeking children.

Key words:

War-affected asylum-seeking children, rehabilitation, social reintegration, psychosocial support.

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Abbreviations

AMC	Admission and Managing Committee
BUP	Child and Adolescent Psychiatric Out-patient Clinic
CASNA	Cellule d'accueil scolaire pour élèves nouveau arrivants
CRC	Convention on the Rights of the Child
CWS	Child welfare services
DGI	Danske Gymnastik- og Idrætsforeninger
ECRE	European Council on Refugees & Exiles
ERF	European Refugee Fund
ICRC	The International Committee of the Red Cross
IMF	International Monetary Fund
IOM	International Organization for Migration
MENJE	Ministère de l'Éducation National et de la Jeunesse
NAKMI	The Norwegian Centre for Minority Health Research
NGO	Non-governmental Organization
NKVTS	Norwegian Centre for Violence and Traumatic Stress Studies
NOAS	Norwegian Organization for Asylum Seekers
OLAI	Luxembourg Reception and Integration Agency
ORK	Ombudscomité fir d'Rechter vum Kand (Ombuds Committee for Children's Rights, Luxembourg)
PTSD	Post traumatic stress disorder
RVTS	Regional Resource Centers for Violence, Traumatic Stress and Suicide Prevention
SALAR	Swedish Association of Local Authorities and Regions
SDQ	Strengths and Difficulties Questionnaire
SfK	Center for Crisis Psychology
SOU	Statens offentliga utredningar
STATEC	Institut national de la statistique et des études économiques du Grand-Duché du Luxembourg
TKT	Team for krigs- och tortyrskadade
UAM	Unaccompanied Minor
UDI	The Norwegian Directorate of Immigration
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	United Nations High Commissioner for Refugees and Stateless Persons
UNICEF	United Nations Children's Fund
WB	World Bank

Summary

Today Norwegian authorities lack a support system to ensure asylum-seeking children who have been victims of, participated in or witnessed acts of war their right to rehabilitation and social reintegration; a right provided them in the Convention on the Rights of the Child (1989, Art. 39) and incorporated into the Norwegian national legislation with precedence over national laws. Nor are asylum-seeking children and youth affected by war systematically identified. In an effort to address critiques put forth by the UN Committee on the Rights of the Child the Norwegian Directorate of Immigration (UDI) and the Norwegian Directorate of Health commissioned the present study to identify *good practices* in a selection of other European countries (Denmark, Sweden and Luxembourg) and *lessons learned* from psychosocial work with war-affected children in the Global South[1] (mainly Save the Children, UNICEF, UNHCR and Red Cross). The ultimate purpose of this assessment was to provide concrete recommendations to Norwegian authorities on how to assist the rehabilitation and social reintegration process of war-affected children seeking asylum in Norway. The project is based on a desk study and qualitative interviews. The empirical data material consists of 16 interviews with practitioners, four with national experts in the case countries and one expert interview in Norway. Interviews were also conducted with five war-affected youth, five parents of war-affected asylum-seeking children and three foster parents for unaccompanied minors.

A policy that aims at realizing the right to rehabilitation and social reintegration of asylum-seeking children who have been affected by war must have a holistic approach, as the development and psychosocial well-being of children are strongly related to and dependent on the social contexts of family, peers, educational institutions and the wider community. Rehabilitation interventions and social re/integration measures need to take into account both protective factors and risk factors; strengthening the former and reducing the latter. Exposure to war and violence is the number one risk factor. Many of the asylum-seeking children bring with them multiple exposures to traumatic experiences. Besides this risk factor the study identifies risk factors inherent in the current asylum and support system, not least linked to cramped living conditions, relocations and broken relationships, living with traumatized parents, an uncertain and stressful everyday situation, and experiencing obstacles to social integration. Lack of competent and confident personnel and structures to provide appropriate assessment and therapeutic care to those children, or those parents, who are traumatized or suffer from other types of mental problems related to war experiences, is also a serious risk factor. At the same time, this study also identified potential protective factors that can play an important role in promoting children's psychosocial wellbeing. Examples of protective factors are, for instance, structured activities, within arenas such as school and kindergarten, a well-established and stable accommodation, but also participation in regular recreational activities, supportive and emotionally available parents, supportive adults outside the family and peer relationships, not least through establishing new social networks with native peers.

[1] The term 'Global South' (or simply 'the South') refers to developing countries, which are located primarily in the Southern Hemisphere (Africa, Latin America, and developing Asia including the Middle East).

Several good practices in the case countries were identified as beneficial and fruitful approaches to assist war-affected asylum-seeking children's rehabilitation and social integration. These good practices and lessons learned from NGOs working in the Global South led to the following 27 recommendations:

Accommodation, care and psychosocial well-being

Recommendation 1: Reduce case processing time for families with children and minimize the number of relocations for children in asylum-seeking families as well as for UAMs. This should include all asylum-seeking children, but particularly those who show signs of distress and psychological problems due to personal traumatic experiences or traumatic experiences and/or high levels of stress in their parents.

Recommendation 2: Provide children in asylum-seeking families living conditions that ensure the child's rehabilitation and a healthy development. All families with children should be ensured decentralised residence facilities in ordinary residential areas. The size of residences must allow some privacy as to ensure that children may be protected from overhearing disturbing adult conversations and provide them with a calm space to do home-work. One bed-room apartments are, consequently, not appropriate.

Recommendation 3: Transfer the responsibility for the care of unaccompanied asylum seekers between 15 and 18 from UDI to the national Child Welfare Service (BUFETAT) to ensure them equal rights and care as other children in Norway.

Recommendation 4: Increase the pool of foster parents to care for UAMs that wish to be included in a family. Particular efforts should be given to recruit foster parents from different ethnicities and cultures so that the pool of foster families may reflect, to the largest extent possible, the population and the newly arrived unaccompanied children. Training of foster parents of UAM should be tailored to include capacity-building on the particularities of war-affected asylum-seeking minors. Training should be offered by the regional BUFETAT offices in collaboration with RVTS. Siblings should be kept together in the same placement, whether in a foster family or in a UAM-home.

Recommendation 5: Ensure that staff at asylum centres with children have the necessary cultural competence and knowledge about symptoms of trauma related to war, the flight and the asylum-seeking situation and how traumatization in parents may impact on the development of children. This competence and the fact that they can observe these children on a regular basis may make asylum centre staff better equipped to identify children who suffer from trauma and are in the need of specialised care. Competence on mental health issues will also equip them to perform preventive work.

Recommendation 6: Ensure a staff ratio that allows staff members enough time to get to know the children and youth and to follow-up those in need of special attention. Staff should be encouraged to be emotionally available, to become a significant adult to asylum-seeking children who struggle to deal with the past or the current situation. Measures to ensure continuity of staff at asylum centres should, if needed, also be implemented. The Norwegian

authorities should make the quality of care (practical and emotional) of asylum-seekers, particularly children the main criterion for entering into agreements with non-public contractors in the management of asylum centres, not low budgets.

Schools and kindergartens: arenas for integration and rehabilitation

Recommendation 7: Ensure asylum-seeking children the right and access to free kindergarten. We recommend inclusion of asylum-seeking children in ordinary kindergartens as this enhances social integration (making native friends and learning the national language) and may also positively impact on their psychosocial well-being and health through the use of appropriate pedagogical approaches like STROF and Joyful Play (see *Good practices on Education*), methods which have proven to have a positive effect on traumatized children. Staff at kindergartens (at least a portion of pre-school teachers) must undertake competence building on how to care and support traumatized asylum and refugee children, as well as training in methods like STROF and Joyful Play.

Recommendation 8: Ensure, to the extent possible, rapid integration of asylum-seeking children into ordinary schools and regular classes (as also recommended by the OECD). Employing intercultural mediators to facilitate a smooth integration process should be considered. Parallel to the integration into ordinary schools teachers should be offered cross-cultural training and competence building on the impacts experiences of war, armed conflict, relocation and flight, may have on children's behaviour and learning processes. The Regional resource centres for violence, traumatic stress and suicide prevention (RVTS) should be involved in such training.

Recommendation 9: The School Health Services at the municipal level must be strengthened as its personnel may play a crucial role in attending to the needs of war-affected asylum-seeking children or refer them to other specialist services. It should have an interdisciplinary approach and include a social curator/worker and a psychologist in addition to the school nurse to better be able to attend to the psychosocial needs of war-affected asylum-seeking children. Here Norway should look to Sweden where the School health services includes an interdisciplinary team of a school nurse, a school doctor, a school curator, a school psychologist as well as a special educator (*spesialpedagog*), while the School health services in Norway most commonly consists of only a school nurse. Due to its presence at schools and because *all children* are called in for check-ups, the School Health Service constitutes a health service arena which is likely to be more accessible and less “scary” to the children.

Participation in recreational activities

Recommendation 10: A standard approach to the rights of asylum-seeking children to recreational activities should be developed and included in the conditions of measures that must be provided by the different operators throughout the country. In other words, we propose a universal approach where all asylum-seeking children, whether accompanied or unaccompanied and independent of where he or she lives, have the same possibility to

participate in recreational activities. Operators should consider adopting the principles of the Motivational System (Attendo, Sweden); Encouraging and motivating asylum-seeking children to participate in regular activities outside the asylum centre or UAM-home. A fixed monthly allowance to cover membership fees should be funded by the operator.

Recommendation 11: Take active steps to raise awareness and encourage different entities, private and public organizations as well as municipalities, to activate children in the asylum-seeking phase. The model of Skellefteå in Sweden is a good example of getting the local community engaged. We stress that recreational activities offered by the NGO sector and municipalities should not take place separately but aim at integrating asylum-seeking children with other children in Norway.

Social support and the importance of supportive adults

Recommendation 12: Establish the measure of *adult support persons* in the Norwegian asylum system aimed at both unaccompanied and accompanied asylum-seeking children. A support person should particularly be provided to those children who are identified as having psychological problems or who are living with a parent with such problems. The support person should preferably be bilingual, speaking the mother-tongue of the child and Norwegian, know well the Norwegian society and cultural norms and be familiar with how to conduct child-friendly conversations about sensitive issues. The support person measure must be time intensive, involving several visits every week. The support person measure should, when deemed necessary due to the problems of the child, be combined with a therapeutic approach through, for instance, weekly sessions with a music or a drama therapist. For a child who is seeking asylum together with his/her family, the measure should have a family-focus where other family members also benefit from the support person. Asylum centres must have a budget that allows hiring external professional consultants to implement this support.

Recommendation 13: Consider the possibility of including a social support function into the representative scheme for unaccompanied asylum-seeking minors.

Identification and assessment of risks and resilience

Recommendation 14: To ensure a swift recognition of and response to psychological problems, a cross-culturally sensitive psychological support program should be established at transit centres in Norway. The *Eng Bréck no baussen* program at the first reception centre in Luxembourg may serve as a model of implementation. The program must involve having a psychologist present at the centre who may attend swiftly to psychological needs. The response to the needs of war-affected asylum-seeking children should have a multilevel approach, involving individual, family and group level interventions as well as social integration measures.

Recommendation 15: Ensure an in-depth assessment of the psychosocial well-being of all asylum-seeking children within two months of arrival. Following recommendation 14, this assessment should be conducted by a psychologist at the transit centres, while also involving

observations of the children by other staff members at the centre and in schools and kindergartens. The result of the psychosocial well-being assessment should be taken into account by the UDI when deciding in which asylum centre or UAM-home to place the child, as it needs to be ensured that the necessary therapeutic treatment as well as other support measures are available. The assessment must be updated regularly throughout the asylum-seeking period.

Recommendation 16: A child-friendly and culturally sensitive interview guide to be used in assessment of asylum-seeking children's psychosocial well-being should be developed. The assessment must seek to identify the strengths and resilience of the child as well as protective factors in his/her surroundings, both types of information being important for how to proceed with regards to rehabilitation and social re/integration measures and interventions. The assessment should ensure the involvement of the child and other main actors in the child's network. Conversations with the child as well as with the parents should also seek to reveal culturally appropriate approaches to healing and recovery.

Recommendation 17: Guidelines on how to conduct quality observations of the psychosocial well-being of asylum-seeking children should be developed and information gathered through observations should form part of the assessment procedure. Staff at transit centres, asylum centres, UAM-homes, schools and kindergartens and representatives (guardians) should be trained on the use of these guidelines. The RVTS should be involved in both the development of and training on these guidelines.

Recommendation 18: Conversations with the child and his/her parents should seek to reveal whether the child has been associated with an armed group or military unit, and if in these circumstances they have become victims or perpetrators of acts of violence. Due to their experiences, former child soldiers[2] might be severely traumatized and be in need of a particular attention and support in order to rehabilitate. These conversations must be carried out in a very sensitive manner, as focusing on these topics might be connected with feelings of shame, guilt and taboo for the children and youth affected, which might impede the thematization. Similarly to the result of the assessment of the psychosocial well-being, information on participation in armed conflict should be taken into account by the UDI when deciding where the child should live while waiting for the result of their asylum case, as specialised health care might be necessary.

Recommendation 19: Health personnel in Health clinics should have the knowledge and expertise needed to identify symptoms of traumatization or other psychological problems of asylum-seeking children and parents. The clinics' personnel must be ensured capacity building on how to recognise symptoms of war-related trauma, particularly trauma symptoms in infants and toddlers. It is further recommended to establish an interagency cooperation with primary and specialist health care services so that these children and their families receive necessary and appropriate health care.

[2] The term child soldier, or children associated with an armed force or armed group, is 'any person below 18 years of age who is or has been recruited or used by an armed force or armed group in any capacity, including but not limited to children, boys and girls, used as fighters, cooks, porters, messengers, spies or for sexual purposes' (UNICEF 2007).

Family-focused psychosocial support

Recommendation 20: Ensure a family-focused approach to psychosocial support (for instance *the adult support person* measure, see *Recommendation 12*) helping parents to cope with their own problems, support parents on how to minimize that their own mental stress and traumas affect their children, and help them understand how to handle the war-trauma reactions of their children. Competent professionals, preferably bi-lingual, should be used in this kind of interventions. Asylum centres must have a budget that allows hiring external professional consultants to implement this support.

Recommendation 21: Offer appropriate psychological and psychiatric treatment to asylum-seeking adults. If necessary, adults with children should be prioritized. The right to psychiatric treatment must be extended to adults who have had their asylum application rejected. Adult psychiatric health services (regional) must be strengthened to be able to provide the necessary, rapid and appropriate psychological and psychiatric treatment to asylum-seeking adults affected by war. A close collaboration with other health services, particularly BUP, is crucial to succeed in improving the health situation in asylum-seeking families.

Therapeutic treatment for children

Recommendation 22: Psycho-education and group interventions such as *friRum* should be organized in asylum centres or in schools with both war-affected and other asylum-seeking children. For children in families, the group intervention should be conducted in close collaboration with parents and include family events where the whole family participates. The groups should be led by a psychologist preferably in collaboration with a teacher with whom the children are already familiar. Such group interventions should be organized through a collaboration between the asylum centres or UAM-homes, schools, municipal Refugee health care services or BUP or potentially also by the involvement of the School health service (see *Recommendation 9*).

Recommendation 23: War-affected (and other) asylum-seeking children in need of trauma therapy or other forms of specialised treatment must be ensured rapid access to treatment. Individual therapeutic approaches may include interventions like Trauma-focused Cognitive-behavioural treatment, Testimonial psychotherapy and Narrative exposure therapy. However, great care must be taken to ensure that children are not re-traumatized due to a too confrontational approach to treatment. Based on the current organization of health care services in Norway, trauma therapy to asylum-seeking children should be provided by BUP. However, to successfully realize this task BUP need more resources (not least with regards to human resources) and more specialised competence on treatment of children with war-related traumas.

Recommendation 24: As it will take time before BUP and the municipal health care structures have the necessary competence and experience, increasing the responsibility of RVTS to also provide treatment of war-affected asylum-seeking children should be considered. Due to the particularities of trauma treatment while in an uncertain asylum situation, it should also be considered to establish specialised mental health services at the municipal level as this will assure better access to treatment than regional structures would. The Transcultural Centre in Stavanger, their interdisciplinary approach and providing both advisory and competence building and direct treatment could potentially be a prototype of such specialised centres.

Recommendation 25: Municipal Refugee health care services (or teams) should be present in every municipality and should employ a *proactive approach* (similar to the one put in place in the aftermath of the Utøya attack) to ensure that those children and families who are not capable of seeking help themselves also should be approached and offered psychosocial assistance.

Recommendation 26: Healthcare providers working with traumatized children may suffer from compassion fatigue or secondary traumatic stress. A system of follow-up and de-briefing of health personnel working directly with traumatized children should be put in place.

Long-term competence plan

Recommendation 27: The impact of war and armed conflict on children's psychosocial well-being and development should become key themes in the long-term competence plan of professionals such as health personnel and teachers and preschool teachers. The education of these professionals must encompass culturally appropriate approaches to learning, psycho-education and mental health care of children suffering from war-related traumas.

Sammendrag

Norske myndigheter mangler i dag et system for å sikre asylsøkende barn som har vært offer for, deltatt i eller vært vitne til krigshandlinger eller andre overgrep sin rett til rehabilitering og sosial re-integrering; en rettighet gitt dem gjennom barnekonvensjonen (1989, Art. 39) som er inkorporert i norsk lov. Asylsøkende barn utsatt for krig blir heller ikke systematisk identifisert. For å imøtegå kritikk fremmet av FNs barnekomite initierte Utlendingsdirektoratet (UDI) og Helsedirektoratet denne studien hvis formål er å identifisere *god praksis* i et utvalg av andre europeiske land (Danmark, Sverige og Luxembourg) og *erfaringer* fra psykososialt arbeid med krigsrammede barn i det globale sør[3] (hovedsakelig Redd Barna, UNICEF, UNHCR og Røde Kors). Hensikten med kartleggingen er å gi konkrete anbefalinger til norske myndigheter om hvordan rehabiliterings- og reintegreringstiltak til asylsøkende barn som har vært rammet av krig bør implementeres. Prosjektet baserer seg på en gjennomgang av relevant litteratur og kvalitative intervjuer. Studiens empiriske datamateriale består av 16 intervju med profesjonelle fra praksisfeltet, fire intervju med nasjonale eksperter i case landene og ett ekspert intervju i Norge. Intervju ble også gjennomført med fem ungdommer rammet av krig, fem foreldre av asylsøkende barn rammet av krig og tre foster foreldre for enslige mindreårige.

En politikk (policy) som tar sikte på å realisere retten til rehabilitering og sosial reintegrering av asylsøkende barn som er rammet av krig må ha en helhetlig tilnærming fordi barns utvikling og psykososial helse er sterkt relatert til og avhengig av sosiale forhold knyttet til familie, jevnaldrende, utdanningsinstitusjoner og samfunnet for øvrig. Rehabiliterings- og sosiale re/integreringstiltak må ta hensyn til både beskyttelsesfaktorer og risikofaktorer gjennom å styrke førstnevnte og redusere sistnevnte. Opplevelsen av krig og vold utgjør den største risikofaktoren. Mange asylsøkende barn har opplevd en rekke traumatiske hendelser. I tillegg til denne risikofaktoren identifiserer studien innebygde risikofaktorer i det nåværende asyl- og støttesystemet, ikke minst knyttet til faktorer som trange boforhold, flytting og brutte relasjoner, det å leve med traumatiserte foreldre, det å ha en usikker og stressende hverdag og hindringer for sosial integrering. Mangel på kompetent og trygt fagpersonell, samt strukturer som kan utrede og gi tilpasset terapeutisk behandling til barna og eventuelt foreldre som er traumatiserte eller lider av andre psykiske problemer knyttet til krigsopplevelser, må også tas i betraktning. Samtidig identifiserer denne studien også potensielle beskyttelsesfaktorer som kan spille en viktig rolle i å fremme barns psykososiale helse. Eksempler på beskyttelsesfaktorer er blant annet strukturerte aktiviteter innenfor arenaer som skole og barnehage, veletablerte og stabile boforhold, men også deltakelse i regelmessige fritidsaktiviteter, støttende og emosjonelt tilgjengelige foreldre, støttende voksne utenfor familien og relasjoner med jevnaldrende, ikke minst gjennom å etablere nye sosiale nettverk og norske venner.

[3] Begrepet det «globale Sør» (eller bare «Sør») refererer til utviklingsland, som i hovedsak ligger på den sørlige halvkule (Afrika, Latin-Amerika, og utviklingsland i Asia inkludert Midtøsten).

Flere gode praksiser fra Danmark, Sverige og Luxembourg har blitt identifisert som nyttige og fruktbare tilnærminger for å støtte krigsrammede asylsøkende barns rehabilitering og sosiale integrering. Identifikasjonen av disse gode praksisene, samt erfaringene fra frivillige organisasjoner som arbeider i det globale Sør har ført til følgende 26 anbefalinger:

Boforhold, omsorg og psykososial helse

Anbefaling 1: Redusere saksbehandlingstiden for familier med barn og minimere antall flyttinger av barn i asylsøkende familier så vel som enslig mindreårige asylsøkere (EMA). Dette bør omfatte alle asylsøkende barn, men spesielt de som viser tegn på stress og psykiske problemer grunnet personlige traumatiske opplevelser eller traumatiske opplevelser og/eller høyt stress nivå hos foreldrene.

Anbefaling 2: Gi barn i asylsøkende familier levekår som sikrer barnets rehabilitering og en sunn utvikling. Alle familier med barn bør sikres desentraliserte boliger i vanlige boligområder. Størrelsen på boligene må legge til rette for noe privatliv som sikrer at barn blir beskyttet mot å overhøre opprivende samtaler mellom voksne, samt gir dem tilgang til et rolig sted hvor de kan gjøre hjemmelekser. Ett-roms leiligheter er dermed ikke hensiktsmessige.

Anbefaling 3: Overføre ansvaret for omsorgen for EMA mellom 15 og 18 år fra UDI til barnevernet (Bufetat) for å sikre disse like rettigheter og omsorg som andre barn i Norge.

Anbefaling 4: Øke antall fosterforeldre som kan ta vare på EMA som ønsker å bli inkludert i en familie. Et spesielt fokus bør rettes mot å rekruttere fosterforeldre fra ulike etniske grupper og kulturer slik at tilgjengelige fosterfamilier gjenspeiler, så langt det er mulig, befolkningen og de nyankomne enslige barna. Opplæring av fosterforeldre for EMA bør inkludere kompetanseheving på særegenhetene ved krigsrammede asylsøkende mindreårige. Kursing bør tilbys ved de regionale Bufetat-kontorene i samarbeid med Regionalt ressurssenter om vold, traumatisk stress og selvmordsforebygging (RVTS). Søsken bør holdes sammen i samme bolig, enten i en fosterfamilie eller i bolig for EMA.

Anbefaling 5: Sikre at ansatte som jobber med barn på asylmottak har nødvendig interkulturell kompetanse og kunnskap om symptomer på traumer knyttet til krig, flytting, flukt og asylsituasjonen, samt hvordan traumatisering av foreldre kan ha innvirkning på barns utvikling. Denne kompetansen og det faktum at de kan observere barna regelmessig kan gjøre ansatte på asylmottak bedre rustet til å identifisere barn som lider av traumer og har behov for tilrettelagt omsorg og behandling. Denne kompetansen vil også være nyttig med tanke på forebyggende tiltak.

Anbefaling 6: Sikre et tilstrekkelig antall ansatte slik at disse har nok tid til å bli kjent med barna, og kan følge opp de som trenger spesiell oppmerksomhet. Ansatte bør oppmuntres til å være følelsesmessig tilgjengelige og være en voksenperson som kan bety noe for asylsøkende barn som sliter med å forholde seg til fortiden eller den nåværende situasjonen. Tiltak for å sikre kontinuitet i personalet på asylmottak bør, om nødvendig, også implementeres. Norske myndigheter bør la kvaliteten på hvordan asylsøkere og spesielt asylsøkende barn blir

ivaretatt (praktisk og emosjonelt), og ikke lave budsjett, være det viktigste kriteriet for å inngå avtaler med private foretak i forvaltningen av asylmottak.

Skoler og barnehager: arenaer for integrering og rehabilitering

Anbefaling 7: Sikre asylsøkende barn rett og tilgang til gratis barnehage. Vi anbefaler inkludering av asylsøkende barn i ordinære barnehager, da dette fremmer sosial integrering (få lokale venner og lære språket). Ved bruk av tilpassede pedagogiske metoder som *STROF* og *Joyful Play* (se *Good practices on Education*), som har vist seg å ha en positiv effekt på traumatiserte barn, kan barnehagen ha en positiv innvirkning på barnas psykososiale helse. Personalet i barnehagen (i det minste en del av staben) må få kompetanseheving på hvordan utøve omsorg for -og støtte traumatiserte asyl- og flyktningebarn, samt opplæring i metoder som STROF og Joyful Play.

Anbefaling 8: Sikre, i den grad det er mulig, rask integrering av asylsøkende barn i ordinære skoler og vanlige klasser (som også anbefales av OECD). Det bør vurderes å ansette flerkulturelle ressurspersoner for å legge til rette for en smidig integreringsprosess. Parallelt med integrering i ordinære skoler, bør lærere få tilbud om interkulturell opplæring og kompetansebygging på hvordan erfaringer med krig, væpnet konflikt, flytting og flukt kan ha innvirkning på barns atferd og læringsprosesser. RVTS bør være involvert i slik opplæring.

Anbefaling 9: Skolehelsetjenesten på kommunenivå må styrkes ettersom dets personell kan spille en avgjørende rolle i å ivareta behovene til krigsrammede asylsøkende barn eller henvise dem til andre spesialisttjenester. Skolehelsetjenesten bør ha en tverrfaglig tilnærming og inkludere en sosialarbeider og en psykolog i tillegg til helsesøster for å bedre ivareta de psykososiale behovene til krigsrammede asylsøkende barn. Her bør Norge se til Sverige hvor Skolehelsetjenesten omfatter et tverrfaglig team av en helsesøster, en skolelege, en skolekurator, en skolepsykolog samt en spesialpedagog, mens Skolehelsetjenesten i Norge vanligvis består kun av en helsesøster. Dets tilstedeværelse på skoler, og fordi *alle barn* innkalles til kontroll, gjør skolehelsetjenesten til en arena som kan tenkes å være mer tilgjengelig og mindre "skummel" for barna.

Deltakelse i fritidsaktiviteter

Anbefaling 10: En standard tilnærming til asylsøkende barns rett til fritidsaktiviteter bør utvikles og inkluderes i porteføljen av tiltak som skal ivaretas av de ulike driftsoperatører av asylmottak i hele landet. Med andre ord foreslår vi en universell tilnærming der alle asylsøkende barn, enten enslige eller med følge og uavhengig av hvor de bor, har samme mulighet til å delta i fritidsaktiviteter. Driftsoperatører bør vurdere prinsippene i the *Motivational System* (Attendo, Sverige); oppmuntre og motivere asylsøkende barn til å delta i vanlige aktiviteter utenfor asylmottak eller boliger for EMA. En fast månedlig kvote for å dekke medlemskontingent bør finansieres av operatøren.

Anbefaling 11: Aktivt bevisstgjøre og oppmuntre ulike enheter, private og offentlige organisasjoner, samt kommuner, til å aktivisere barn i asylfasen. Modellen fra *Skellefteå* i Sverige er et godt eksempel på å engasjere lokalsamfunnet. Vi understreker at

fritidsaktiviteter som tilbys av frivillig sektor og kommunene ikke bør foregå segregert, men ta sikte på å integrere asylsøkende barn med andre barn i Norge.

Sosial støtte og betydningen av støttende voksne

Anbefaling 12: Etablere et tiltak med *voksne støttepersoner* i det norske asylsystemet rettet både mot enslige asylsøkende barn og barn som kommer med sin familie. En støtteperson bør særlig bli tilbudt barna som har en eller annen form for psykiske problemer eller som lever med en forelder med slike problemer (se praksisen *Family-focused psychosocial support, Denmark* under *Good practices regarding Psychological support*). Støttepersonene bør fortrinnsvis være tospråklige, beherske barnas morsmål og norsk, kjenne godt til det norske samfunnet og kulturelle normer, samt vite hvordan de skal gjennomføre barnevennlige samtaler rundt sensitive spørsmål. Tiltaket må være intensiv og involvere flere besøk hver uke. Det bør, når det anses nødvendig av hensyn til barnet, kombineres med en terapeutisk tilnærming gjennom, for eksempel, ukentlige økter med en musikk- eller dramaterapeut. For barn som søker asyl sammen med sin familie, bør tiltaket være familie-fokusert der andre familiemedlemmer også kan ha nytte av støttepersonen. Asylmottak må ha et budsjett som tillater innleie av eksterne profesjonelle konsulenter for å gjennomføre dette tiltaket.

Anbefaling 13: Vurdere muligheten for å inkludere en sosial støttefunksjon i representantordningen for enslige mindreårige asylsøkere.

Identifisering og vurdering av risiko og resiliens

Anbefaling 14: For å sikre en rask identifisering og respons på psykiske problemer, bør et interkulturelt sensitivt psykologisk støtteapparat etableres ved transittmottakene i Norge. *Eng Bréck no baussen* programmet ved mottaket i Luxembourg kan tjene som en modell for gjennomføringen. Programmet må involvere tilstedeværelse av en psykolog på senteret som kan hjelpe raskt ved psykologiske behov. Responsen på behovene til krigsrammede asylsøkende barn bør ha en tilnærming på flere nivå, som inkluderer intervensjoner på individ-, familie- og gruppenivå, samt sosiale integreringstiltak.

Anbefaling 15: Sikre en grundig utredning av psykososial helse hos alle asylsøkende barn innen to måneder etter ankomst. I henhold til anbefaling 14, bør denne utredningen foretas av en psykolog på transittmottakene, men også involvere observasjoner av barna gjort av andre ansatte på senteret og i skoler og barnehager. UDI bør ta resultatet av utredning av psykososial helse med i betraktning når de bestemmer i hvilket asylmottak eller boliger for EMA barnet skal plasseres på, siden det må sikres at den nødvendige terapeutiske behandlingen samt andre støttetiltak er tilgjengelig. Utredningen må oppdateres jevnlig gjennom hele asylsøker perioden.

Anbefaling 16: En barnevennlig og kulturelt sensitiv intervjuguide for bruk i utredningen av asylsøkende barns psykososiale helse bør utarbeides. Utredningen må søke å identifisere styrker og robusthet i barnet samt beskyttende faktorer i barnets omgivelser, siden denne informasjonen er viktig med hensyn til rehabilitering og sosial (re)integreringstiltak og intervensjoner. Utredningen bør sikre involvering av barn og andre hovedaktører i barnets

nettverk. Samtaler med barnet så vel som med foreldrene bør også søke å avdekke kulturelt passende tilnærminger til rehabilitering.

Anbefaling 17: Retningslinjer for gjennomføring av observasjoner rundt psykososial helse hos asylsøkende barn bør utarbeides og informasjon samlet gjennom observasjonene bør inngå i utredningsprosessen. Ansatte ved transittmottak, asylmottak, boliger for EMA, skoler og barnehager samt representanter (verger) bør opplæres i bruken av disse retningslinjene. RVTS bør være involvert i både utarbeidelsen av og opplæring i disse retningslinjene.

Anbefaling 18: Samtaler med barnet og barnets foreldre bør søke å avdekke om barnet har vært tilknyttet en væpnet gruppe eller militær enhet, og om de under disse omstendighetene har vært ofre for eller har utført voldshandlinger. På grunn av sine opplevelser kan tidligere barnesoldater[4] bli alvorlig traumatisert og ha behov for spesiell oppmerksomhet og støtte for å kunne rehabiliteres. Disse samtalene må gjennomføres på en meget skånsom måte, siden det å fokusere på disse temaene kan være forbundet med skamfølelser, skyld og tabu for de berørte barna og ungdommene noe som kan forhindre åpenhet om temaene. I likhet med resultatene av utredningen av psykososial helse, bør informasjon om deltakelse i væpnet konflikt tas i betraktning av UDI når de bestemmer hvor barnet skal bo mens de venter på utfallet av sin asylsak, siden spesialiserte helsetjenester kan bli nødvendig.

Anbefaling 19: Helsepersonell på Helsestasjonene bør ha den nødvendige kunnskap og kompetanse for å kunne identifisere symptomer på traumatisering eller andre psykiske problemer hos asylsøkende barn og foreldre. Helsestasjonenes personell må sikres kompetanseutvikling om hvordan de kan gjenkjenne symptomer på krigsrelaterte traumer, spesielt traumesymptomer hos spedbarn og småbarn. Det anbefales videre å etablere et tverretatlig samarbeid med primær- og spesialisthelsetjenesten, slik at disse barna og deres familier får nødvendig og hensiktsmessig behandling.

Familiefokusert psykososial støtte

Anbefaling 20: Sikre en familiefokusert tilnærming til psykososial støtte (for eksempel gjennom *støtteperson-tiltaket,* se Anbefaling 12) ved å hjelpe foreldre å takle sine egne problemer, støtte foreldre i hvordan minimalisere at deres eget mentale stress og traumer påvirker barna, samt hjelpe dem til å forstå hvordan de skal håndtere reaksjoner knyttet til krigstraumer hos sine barn. Kompetente fagfolk, helst tospråklige, bør brukes i denne typen tiltak. Asylmottak må ha et budsjett som tillater innleie av eksterne profesjonelle konsulenter for å gjennomføre dette tiltaket.

Anbefaling 21: Tilby tilpasset psykologisk og psykiatrisk behandling til asylsøkende voksne. Om nødvendig bør voksne med barn prioriteres. Retten til psykiatrisk behandling må utvides til voksne som har fått avslag på sin asylsøknad. Voksenpsykiatriske helsetjenester (regionale) må styrkes for å kunne gi nødvendig, rask og riktig psykologisk og psykiatrisk behandling til

[4] En barnesoldat, eller barn som har vært tilknyttet en væpnet grupper, er 'enhver person under 18 år som er eller har vært rekruttert eller brukt av en væpnet styrke eller væpnet gruppe uansett arbeidsoppgaver, inkludert men ikke begrenset til barn, gutter og jenter, som brukes som krigere, kokker, portører, budbringere, spioner eller til seksuelle formål' (UNICEF, 2007).

asylsøkende voksne rammet av krig. Et nært samarbeid med andre helsetjenester, spesielt BUP, er avgjørende for å lykkes i å forbedre helsesituasjonen i asylsøkende familier.

Terapeutisk behandling av barn

Anbefaling 22: Psykologisk mestringsundervisning (psycho-education) og gruppeintervensjoner som *friRum* bør organiseres i asylmottak eller i skoler med både krigsrammede og andre asylsøkende barn. For barn i familier, bør gruppeintervensjoner gjennomføres i nært samarbeid med foreldre og inkludere familiebegivenheter der hele familien deltar. Gruppene bør ledes av en psykolog, og gjerne i samarbeid med en lærer som barna allerede kjenner. Slike gruppeintervensjoner bør organiseres gjennom et samarbeid mellom asylmottak eller boliger for EMA, skoler, kommunale flyktningehelsetjenester eller BUP, potensielt også med involvering av skolehelsetjenesten (se anbefaling 9).

Anbefaling 23: Krigsrammede (og andre) asylsøkende barn som har behov for traumebehandling eller annen form for spesialisert behandling må sikres rask tilgang til behandling. Individuelle terapeutiske tilnærminger kan omfatte tiltak som traume-fokusert kognitiv atferdsbehandling, vitnesbyrdmetoden og narrativ eksponeringsterapi. Imidlertid må det utvises stor forsiktighet for å sikre at barn ikke retraumatiseres på grunn av en altfor konfronterende tilnærming til behandling. Basert på dagens organisering av helsetjenester i Norge, bør traumebehandling til asylsøkende barn gis av BUP. Men for å lykkes med å realisere denne oppgaven trenger BUP flere ressurser (ikke minst menneskelige ressurser) og mer spesialisert kompetanse på behandling av barn og krigsrelaterte traumer.

Anbefaling 24: Ettersom det vil ta tid før BUP og kommunale helsestrukturer har nødvendig kompetanse og erfaring, bør det vurderes å øke ansvaret til RVTS ved å inkludere direkte behandling av krigsrammede asylsøkende barn. På grunn av de spesielle omstendighetene ved traumebehandling i en usikker asylsituasjon, bør det også vurderes å etablere spesialiserte psykiske helsetjenester på kommunalt nivå siden det vil sikre en bedre tilgang til behandling enn regionale strukturer kan. Transkulturelt senter i Stavanger, deres tverrfaglige tilnærming og at de både gir råd, driver kompetansebygging og gir klinisk behandling kan potensielt være en prototype for slike spesialiserte sentre.

Anbefaling 25: Kommunale flyktninghelsetjenester (eller team) bør være til stede i hver kommune med en proaktiv tilnærming (som ble iverksatt i etterkant av terrorangrepet på Utøya) for å sikre at de barna og familiene som ikke er i stand til å søke hjelp selv blir oppsøkt og tilbys psykososial hjelp.

Anbefaling 26: Helsepersonell som arbeider med traumatiserte barn kan lide av ‘compassion fatigue’ eller sekundært traumatisk stress. Et system for oppfølging og debrifing av helsepersonell som arbeider direkte med traumatiserte barn bør implementeres.

Langsiktig kompetanseplan

Anbefaling 27: Virkningen av krig og væpnet konflikt i forhold til barns psykososiale helse og utvikling bør bli sentrale tema i de langsiktige kompetanseplanene for fagfolk som

helsepersonell, lærere og førskolelærere. Disse utdanningene må omfatte temaer som kulturelt tilpassede tilnærminger til læring, psykologisk mestringsundervisning (psycho-education) og psykisk helsevern for barn som lider av krigsrelaterte traumer.

1 Introduction

Around the globe, there are millions of people fleeing from war, violence and persecution. About half of these are children and youth under the age of 18, fleeing with or without their parents. The majority of refugee children affected by war are either internally displaced and refugees in their own countries or refugees in neighbouring countries. However, some seek asylum and refuge in the Western part of the world. According to figures from the Norwegian Directorate of Immigration (UDI), Norway received 11,983 asylum seekers in 2013, of whom 1,070 were unaccompanied asylum-seeking minors (UAMs) and 1,700 were children below 18 arriving together with their family (UDI 2013). The 6 top countries of origin of all asylum seekers in Norway - Eritrea, Somalia, Syria, Afghanistan, Sudan and Nigeria – are known to be either war and conflict ridden areas or countries where persecution and violence is frequent.

A young refugee coming from a country experiencing war or armed conflict is not automatically a victim of war. However, it is likely to believe that a rather large part of these children have experienced direct or indirect consequences of armed conflict (see e.g. Bean et al. 2007; Derluyn et al. 2008; Derluyn et al. 2009). Oppedal and colleagues' study (2011) on psychological health and social integration of unaccompanied minors (UM) in Norway found that almost 80 % had experienced war close up, more than half suffered from post-traumatic stress disorder (PTSD) and more than half also reported to have strong memories from war-related experiences. Asylum-seeking children who have been victims of, participated in or witnessed acts of war may therefore be in need of extra support and assistance to recover and to manage their life and present situation. Most war-affected children, also former child soldiers[5], are "(…) functional and, with proper support, can transition to positive lives as civilians" (Wessells 2006: x).

The important question is what can be done to rehabilitate and social reintegrate war-affected asylum-seeking children. Which measures and interventions are perceived as having a positive effect on the psychosocial well-being of war-affected asylum-seeking children? The present study seeks to answer these questions through an assessment of what is done in Denmark, Sweden and Luxembourg and lessons learned from approaches to rehabilitation and social reintegration used by international organizations in the Global South.

The rights of war-affected children

Most states have signed and ratified several conventions and standards that are to direct action with regards to war-affected asylum-seeking children and youth (please find an explanation of this concept in the section *Operationalization and Conceptualization*). Some of these, like the UN Convention on the Rights of the Child (CRC), are guided by the *Best Interest of the Child* principle (UN 1989, Art. 3). From this principle follows an overarching 'obligation' to ensure,

[5] The term child soldier, or children associated with an armed force or armed group, is 'any person below 18 years of age who is or has been recruited or used by an armed force or armed group in any capacity, including but not limited to children, boys and girls, used as fighters, cooks, porters, messengers, spies or for sexual purposes' (UNICEF 2007).

to the maximum extent as possible, not only the survival but also the development of the child (Ibid., Art.6). The particular rights of children affected by war and armed conflict are highlighted in Article 39 of the Convention where states have committed themselves to implement all appropriate measures to promote physical and psychological recovery and social reintegration of children who are victims of war and armed conflict. In Article 6.3 in the Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict (UN 2000) the right to rehabilitated and social reintegration is reaffirmed. The Optional Protocol also underlines the responsibility of the international community by demanding states to cooperate in the implementation of the protocol, for instance, with regards to aspects like rehabilitation and social reintegration (Ibid. Art. 7.1).

The CRC declares that states do not have the authority to discriminate between asylum-seeking and other children when asylum-seeking children reside in the country. This follows from Article 2 (1): *"*States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind.*"* The CRC also underlines and makes explicit refugee children's right to appropriate protection and humanitarian assistance (UN 1989, Art. 22). Therefore, throughout all actions, also during the reception period, asylum-seeking children should, first and foremost, be treated as children with similar rights as all other children, not as refugees. It will, for instance, "be a violation of the Convention on the Rights of the Child to give decisive weight to considerations which regulate immigration if this cannot be considered to be justified by an assessment of the interests of the child" (Meld.St. 27 (2011-2012); see also Ot.Prp. Nr 75 (2006-2007), authors' translation). [6] The best interest of the child should and must be the primary consideration in all child care and child protection measures (UNHCR 1997: 1).

1.1 Background and aim of the project

Despite the ratification of the CRC and the Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict (UN 2000), most countries fail to realize war-affected children's right to rehabilitation and social reintegration (see country reports by UN Committee on the Rights of the Child). In the latest report on Norway's compliance with the Convention, the UN Committee criticized Norway for its "cursory identification of children affected by armed conflict" and recommended Norwegian authorities to "ensure rehabilitation and social reintegration of these children" (UN 2010: 10 & 11). In an effort to address this critique, and as Norway currently does not have any specific measures in place for war-affected children, the UDI and the Norwegian Directorate of Health commissioned the present study. The study aimed to assess practices in other countries in this area, complemented by an overview of international guidelines and of good practices on rehabilitation and reintegration of children in war-affected countries.

[6] When reviewing practice this may not always be the reality. In a recent report to Norwegian authorities the Committee on the rights of the child (2010) notes that they are "concerned that the principle of primary consideration of the best interests of the child is not yet applied in all areas affecting children", highlighting immigration cases as one such area.

The overall aim of the project is accordingly to *identify measures and good practices.* The assessment of what is done elsewhere will culminate in recommendations and suggestions on how Norwegian authorities may develop a better support system for asylum-seeking children who have been victims of, participated in or witnessed acts of war. Denmark, Sweden and Luxembourg were selected as case countries (please see the section *Methodological approach*). The identified measures' transferability to the Norwegian context is of great importance, and therefore we include reflections of employees working with asylum-seeking children in the Norwegian context. In addition, there is a description of the structures, resources and rehabilitation measures Norway established to support youth survivors of the terror attack that took place in Utøya on 22 July 2011.[7]

It should be underlined that this report does not aim to critically and systematically evaluate rehabilitation and social reintegration programmes or measures; neither in Norway nor in the case countries. It rather identifies what is believed to be *good practices* and *lessons learned* elsewhere with the purpose of assisting the Norwegian authorities to improve their own rehabilitation and social reintegration assistance to asylum-seeking children affected by armed conflicts.

1.2 Operationalization and conceptualization

The focus of the study is *on asylum-seeking children who have been victims of, participated in or witnessed acts of war*. In this context, acts of war (and war-related abuses) denote both direct and indirect consequences of armed conflict. The children in question may have experienced bombings, the loss of a father, mother or other family members due to the war, may have witnessed killing, rape or mutilation, have been living in constant fear of armed attacks, may be former child soldiers, or are victims of abduction, rape or other forms of sexual violence, mutilation, torture and death threats. In the report, the shorter term *war-affected asylum-seeking children* will be used. For the purpose of this project, we include all children living in asylum centres, or equivalent accommodation arrangements, independently of the status of their asylum application; those awaiting the final outcome of their asylum application, those who have been granted permanent or temporary residence permits but are not yet settled in a municipality, and those who have had their asylum application refused but are awaiting the return to their country of origin.

A *child* is defined according to the definition in the Convention on the Rights of the Child (UN 1998) as a person below 18. The report will take into account children seeking asylum together with their parents and families as well as those who arrive alone (UAMs). Although the shared experience of war, conflict and violence of both UAMs and children in families gives them many similarities, the fact that UAMs go through all these experiences (also in the host country) without parental support, renders it necessary to distinguish between these two groups (accompanied and unaccompanied minors) when rehabilitation and social reintegration measures are initiated.

[7] Youth were attacked during a political youth party camp resulting in 69 deaths, 60 injuries and 495 survivors.

For the sake of clarifying what we mean by social reintegration and rehabilitation, we would like to draw attention to the Paris Principles and Guidelines on Children Associated with Armed Forces or Armed Groups (UNICEF 2007). These Principles present guidelines on how to protect children from war and how to assist their disarmament, demobilization and reintegration. According to the Paris Principles *child reintegration* is:

> (…) the process through which children transition into civil society and enter meaningful roles and identities as civilians who are accepted by their families and communities in a context of local and national reconciliation. Sustainable reintegration is achieved when the political, legal, economic and social conditions needed for children to maintain life, livelihood and dignity have been secured. This process aims to ensure that children can access their rights, including formal and non-formal education, family unity, dignified livelihoods and safety from harm (UNICEF 2007: 7).

Social reintegration is, thus, a multidimensional process encompassing political, legal, economic and social dimensions, and the Principles highlight that education, family unity, dignified livelihoods and safety from harm are important means in order to reach reintegration. The Paris Principles moreover underline support for families and communities into which the children are reintegrated, family-based care arrangements, supporting children in finding a role in their community, and addressing health-related needs as important instruments. Psychological distress caused by war is acknowledged, and *rehabilitation* should involve assisting those with emotional and behavioural problems, and allowing every child to talk about past experiences either individually or in a group. Recreational activities, education and livelihood opportunities are also highlighted as important elements of a recovery process. This is linked to the fact that the psychosocial well-being often depends on how quickly and how well a sense of normalcy and predictability can be re-established in the lives and daily routines of war-affected children.

Based on the above-mentioned definitions, the conceptualization of *reintegration* in this project focuses on two parts: 1) the functional aspects of integration such as children's integration into kindergarten, education (securing employment), their language acquisition and housing arrangements, and 2) integration into social networks and spaces (relational integration). *Rehabilitation* involves both physical and psychological recovery. The report will have particular focus on psychological rehabilitation, as it can be assumed that the need for physical rehabilitation is likely to be detected and dealt with by general health interventions, with which war-affected asylum children, as all asylum children, automatically come in contact with (e.g., general doctors).

When dealing with psychological rehabilitation of war-affected children, the question of *traumatization* has to be taken into account. If people experience a (life-)threatening event which is beyond their control, it can lead to traumatization or other types of psychological problems. According to the World Health Organisation's "International Classification of Diseases" (ICD 10), trauma "(…) arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone". Trauma

caused by man-made disasters such as war, torture or rape, have more serious consequences than natural disasters, because they fundamentally undermine the trust in human relationships.

Post-traumatic stress disorder (PTSD) is one of several possible results of traumatic events. PTSD is characterized by three typical groups of symptoms: 1) *Re-experiencing symptoms, "flashbacks"* (nightmares or vivid, repetitive and persistent memories), 2) *Avoidance symptoms* (social withdrawal, extreme forgetfulness, dissociation or consciously or subconsciously avoiding stimuli which could remind them of the traumatic event) and 3) *Hyperarousal* (extreme alertness, strong reactions of alarm and shock, irritation and rage, insomnia and/or difficulties to concentrate). At the same time, concepts and the understanding of mental health problems may also vary according to culture (Kostelny 2006). This is, for instance, the case with PTSD, which may not be a useful approach to mental health issues in non-western contexts or among a war-affected population seeking refuge in a new country. As maintained by Kostelny (2006: 22), "(…) [a]lthough the PTSD concept has been validated and has value in some contexts, a focus on trauma can marginalize other effects of war such as mistrust, hopelessness, social exclusion, and the current stresses of daily life." It has also been argued that it is a diagnosis that does not function optimally with regards to children, because a clear distinction between those with PTSD and children with no posttraumatic suffering is difficult to make as certain symptoms are common among most refugee children (Hjern & Jeppsson 2005: 120).

Due to the above mentioned dilemmas we have chosen not to address PTSD or any other specific mental health diagnosis. We rather address psychological problems among asylum-seeking children having experienced traumatic war-related events.

In the Terms of Reference (ToR), the UDI and the Directorate of Health asked us to identify *best practices*. A common definition of *Best Practice* is tied to the idea of "(…) accumulating and applying knowledge of what is working and not working in different situations and contexts. In other words, it is both the lessons learned and the continuing process of learning, feedback, reflection and analysis (what works, how and why, etc.)" (Bendixsen & Guchteneire 2003: 677). Best Practice does, therefore, not imply that it is the "ultimate truth" rather that it has proven successful according to pre-set criteria. UNESCO (*MOST Clearing House. Best Practices*) proposes that a best practice should have the following four characteristics:

1. Best practices are innovative (new and creative solutions to common problems)
2. Best practices make a difference (demonstrate a positive impact on the living conditions, quality of life or environment of those concerned)
3. Best practices have a sustainable effect
4. Best practices have the potential for replication (elsewhere)

The framework of the present project did not allow us to evaluate measures and interventions according to this standard for best practices. Where available, we reviewed evaluation reports, but some of the measures and practices identified as having a positive impact were relatively new and had not yet undergone a thorough external evaluation. Therefore, we have chosen to use the term *good practices* rather than *best practices* when describing and discussing the case

studies in Sweden, Denmark and Luxembourg. It should be noted that we still use the term best-practice when referring to some international guidelines in chapter three in which this term is used.

1.3 The plight of war-affected asylum-seeking children

Acts of war constitute a large variety of abuses and atrocities, all of which may have traumatic consequences for exposed children. Derluyn et al. (2004), in their study on former child soldiers in Northern Uganda (a total of 301), find that 77 % had seen someone being killed and 39 % had killed someone themselves. Amone-P'Olak (2005), focusing his research on formerly abducted girls, finds that "98 % of girls had been threatened to be killed when disobeying, 98% had thought that they would be killed, 99 % only narrowly escaped death, 72 % had been sexually abused by the rebels (in most cases forcefully 'being given as a wife' from the age of 13 years), 65 % witnessed people being killed, 44 % of girls witnessed people being mutilated, 18 % of the girls participated in killings, and 7 % were forced to participating in killing own relatives" (Shauer & Elbert 2010: 323). Similar findings were found in a study of Vindevogel and colleagues (2011).

Also children that never have been recruited and used by armed forces and groups are highly exposed to war-related traumatic experiences, as shown in the studies of Mels and colleagues on war-affected youth in Eastern Congo (Mels et al. 2009, 2010). Many experience and personally witness family members and friends being killed, mutilated and/or raped. Others lose family members and friends due to illness indirectly caused by the war. Armed conflict forces, moreover, families to flee their homes, and children often end up being separated, finding themselves alone without adult protection and care. In short, war disrupts the familial and societal safety systems that normally would protect the children (Machel 1996).

Most war-affected children have multiple experiences of traumatic events (e.g., Derluyn et al. 2004; Amone-P'Olak 2005). Many of these children, not least child soldiers, have experienced a series of traumatic events, maybe even daily, within a timeframe that may last for a few months to several years. The intensity and number of traumatic events, as well as the overall duration of the exposure to such incidents, are all important factors impacting on the child's psychological condition. How war-affected children cope is not only dependent on their personal exposure to traumatic events but also dependent on parents' exposure and coping with war traumas (Montgomery & Linnet 2012). Normally a child would turn to his or her parents for comfort and support. However, when the parents are also traumatized this often results in a lack of or a reduced ability to care for their children. When researching children in Iraq following the Gulf war, Dyregrov et al. (2002: 136) found that "(…) there was a strong adult denial of the painful material children struggled with, often as a consequence of adults' problems in dealing with their own traumatic after-effects from the war".

War-affected children seeking asylum in an exile country are, in addition to war-related traumatic events in the home country, also exposed to an often long and possibly dangerous flight, which in most cases passes through several countries. The causes of psychological problems in refugee and asylum-seeking children are not limited to traumatic experiences that happened in the home country only, but might also be caused, or aggravated, by experiences during the flight, and by experiences and living circumstances in the host country (Miller & Rasmussen 2010; Derluyn & Broekaert 2005; Vervliet, 2013). Arriving at the final destination, they find themselves in a foreign country with unfamiliar social rules and cultural clues, a language they don't understand and with a very small social network, if any at all. Particularly for the unaccompanied minor asylum seekers the arrival phase is characterized by a huge sense of loss and loneliness. The UngKul project in Norway found, for instance, that 75 % of unaccompanied minors felt lonely (Oppedal et al. 2008: 16). On top of everything else, applying for asylum involves months and possibly years of living in a "standby-phase" characterized by uncertainty and worries about the future. Prolonged waiting and uncertainty related to the outcome of the application for asylum is viewed as the biggest threat to children's psychological wellbeing and health following after traumatization and separation from parents.

1.4 Organization of the report

The remaining parts of the report are organized in six chapters. The following chapter, chapter two, outlines the theoretical framework and the methodological approach of this assessment of rehabilitation and social re/integration measures.

Chapter three presents inspiration from guidelines, recommendations and best practices of international and national organizations. This chapter includes different approaches towards caring for war-affected children and programming.

Chapter four presents the case studies: Denmark, Sweden and Luxembourg. The case studies are described according to six main subjects related to psychosocial support: ownership and organization, accommodation, education, recreational activities, health care and rehabilitation and representatives/ guardians. At the end of each subject description, we present good practices identified through the analysis of the case studies.

Chapter five sheds light on the Norwegian context and offers an impression of existing and possible measures for war-affected asylum-seeking children at different levels in the Norwegian society. This chapter includes a description of relevant measures that were taken to support youth survivors of the terror attack on July 22nd, 2011. It also includes an example of regional and local institutions ensuring psychosocial support to asylum-seeking children and youth.

In chapter six, we discuss different subjects relating to identifying war affected asylum-seeking children and providing psychosocial support. The subjects that are raised are accommodation, education, recreational activity, social support and support person, identification and assessment of children's psychosocial well-being, accessibility of

therapeutic treatment, family focused support and mainstream versus specialised services. The discussion within each subject leads to recommendations aimed at Norwegian authorities.

In chapter seven we make some concluding remarks on war-affected asylum-seeking children and the realization of their right to rehabilitation and social reintegration.

2 Theory and Methodology

2.1 Theoretical starting point

In this project, we do not only focus on human trauma and reactions to such trauma within an individual framework, but the development and reactions of children affected by war will be understood in relation to the social context in which it occurs (Bateson 2000). Our starting point is that human development is the result of the interaction between a developing human being and his or her context. In line with Bronfenbrenner (1994), we view a person's social context as composed by different systems that mutually influence each other. In Bronfenbrenner's ecology model of human development, he proposes five different subsystems: 1) *Microsystems*, including immediate environment such as family, friends and peers, school, and neighbourhood, 2) Mesosystems, denoting the relation between two or more of the microsystems, for instance, between the family and the school, 3) *Exosystems*, which involve the relation between two or more systems in which at least one does not involve the developing person him/herself (for instance parents' workplace), 4) *Macrosystems*, which is "(…) the larger cultural context and its overarching institutional patterns in terms of society's economic, social, legal and political systems (e.g. asylum policy) that affect and is manifested in the micro-, meso-, and exosystems*"* (Montgomery & Linnet 2012: 21 – author's translation), and lastly 5) *Chronosystems*, which encompasses a change or a transition in a person's life that is "(…) not only in the characteristics of the person but also of the environment in which that person lives" (Bronfenbrenner 1994: 40).

The present report will mainly focus on microsystems and to a smaller degree also some systems at the macro level. It aims at investigating how measures and practices of rehabilitation and social reintegration target different systems, and how measures aiming at one system may positively impact on other systems. Settings such as family, school, peer interaction, and home and neighbourhood are of particular importance, as is the relation *between* these microsystems and the larger society (macro). The report will also to some extent focus on *chronosystems*, the relevance being that important life events, for example the exposure to war-related traumatic events and the transition involved when becoming an asylum seeker, directly or indirectly affect the social reintegration process of these children.

In line with the theoretical framework of social ecology and to avoid a sole focus on psychological trauma and mental health, we use the term *psychosocial well-being* and interventions. We see this term to neatly unite the two aspects under study: rehabilitation and social reintegration. Psychosocial well-being underlines the relationship between the psychological and social domains of the human experience, and how the two domains mutually affect and depend on each other (Verhey 2001). On the one hand, we have psychological aspects, aspects that affect the mind, emotions, behaviour, memory etc. Studies on child soldiers, for instance, show high levels of traumatic stress, often manifested through symptoms such as sleeping problems, nightmares, depression, fear and/or panic attacks, lack of concentration, aggressive behaviour and apathy and isolation. These psychological

problems should be met with measures aiming at rehabilitation and recovery. Social aspects, on the other hand, refer to the relationship between an individual and different levels of society. In our case, we are interested in the war-affected asylum child's social integration into different spheres of society such as family, neighbourhood, school, work, peers and other social networks (micro), and into the culture and values of the society where they live (macro). We see social (re)integration and psychological rehabilitation as mutually reinforcing each other: A war-affected child is more easily reintegrated if psychological recovery has taken place, and social reintegration and the feeling of belongingness contribute to the child's healing process (Baumeister & Leary 1995; Tonheim 2014: 641). Contrary, "(…) lack of attachment and social exclusion is often linked to a variety of ill effects on health, adjustment, and general well-being" (Baumeister & Leary 1995: 497).

This project shares the view of the Paris Principles that "(…) psychosocial support should focus on identifying and addressing any obstacles to the ability to develop an appropriate social role and engage in culturally expected social relationships*"* (2007, Art.7.74). Subsequently, the project seeks to identify possible obstacles to the rehabilitation and social reintegration of war-affected asylum children. These obstacles may also be called risk factors. As noted by Montgomery & Linnet (2012: 22 – authors' translation), "(…) psychosocial work must be designed to help reduce risk factors and strengthen protective factors for each child", and here for a particular group of children: war-affected asylum children. This report shows that many practitioners and experts working with this issue highlight the *organization and coordination of interventions* as an important premise to be able to rehabilitate and socially reintegrate these children. Collaboration across government agencies, locally and nationally, as well as collaboration with civil society organizations particularly equipped to provide psycho-social assistance to war-affected children will be presented.

2.2 Methodological approach

The project has a qualitative methodological approach. It aims at understanding the relationships between a range of not-easily-measurable variables through an exploration utilizing small samples, and places emphasis on narrative and descriptive results. The tools to collect data were desk study/review, individual interviews and one group interview.

The project is not an in-depth empirical research project but one that aims at assessing how three other countries address war-affected asylum-seeking children's right to rehabilitation and social re/integration. The focus is on concrete measures and interventions, and the practical implementation and possible positive impact of such interventions. It should, however, be underlined that the project does not aim at *evaluating* the outcomes and impact of interventions, rather the identification of good practices relies on the review of evaluation reports conducted by others and on the viewpoints of experts, practitioners and asylum-seeking parents and youth interviewed in the three case countries as well as in Norway. The interviews at asylum centres and UAM-homes did not only provide valuable information regarding how psychosocial support for war-affected asylum-seeking children should look like, but also these interviews, not least those with parents and youth, were essential to broaden our understanding of the past and current situation of asylum-seeking minors from

war-ridden countries as well as giving us a better insight into the everyday life at asylum centres.

The first research question - *what is done in other European countries to rehabilitate and social reintegrate war-affected asylum-seeking children?* - is answered through a comprehensive description of practices and interventions identified in the three European case countries. The descriptive part is based on 1) a desk study of written materials on the asylum system support in general and more specifically on rehabilitation and re-/integration measures provided to asylum-seeking children and 2) on interviews with experts, practitioners and asylum-seeking youth and parents. Lessons learned from interventions implemented by NGOs working with war-affected children and youth are also incorporated, as is some literature on integration of asylum children in general. The selection of country cases and the design of the case studies are described in more details below.

The next question we ask is: *Which interventions appear to impact most positively on the psychosocial well-being of war-affected asylum-seeking children and how are such interventions best organized?* To address this question we had three approaches:

1) Best-practice guidelines and recommendations from NGOs like Save the Children, UNICEF, UNHCR and Red Cross, on rehabilitation and social re/integration of war-affected children in both the Global North and the Global South. The focus is only on *good practices* which can be used in Norway and which relate not only to war-affected children, but also to refugee or asylum-seeking minors. *Good practice* research is based on the idea that instead of formulating an abstract ideal state we want to reach, we should develop what has been or is being implemented and is proven to work somewhere else. *Guidelines*, on the other hand, suggest general directions of action and conditions to be met rather than specific practices. The main criteria for selection was that guidelines must, above all, fulfil United Nations High Commissioner for Refugees' (UNHCR) proposition that "The basic guiding principle in any child care and protection action is the principle of the `best interests of the child`" (UNHCR 1997: 1). Moreover, we chose to present guidelines that demonstrated practicality, adaptability and repeatability (i.e., those whose importance was stressed by several actors in the field).

2) Findings from the country cases (see section below).

3) Review of the rehabilitation measures put in place for the young victims of the Utøya massacre on 22 July 2011. The description of the measures as well as how the implementation is organized is based on recent reports on the psychosocial efforts and long-term follow-up of the Utøya victims (Kärki 2014; Helsedirektoratet 2012). Although we are not assessing the reception and support of war-affected asylum-seeking children in Norway, we found it fruitful to include a small case study from the local context, both in order to get a better understanding of particular challenges and good approaches but also as part of analysing transferability of good practices identified in the three case countries to the Norwegian context. The data collection took place in Sandnes and Stavanger and consists of qualitative

interviews with one expert, Aina Basilier Vaage, a Child psychiatrist at the Transcultural centre in Stavanger, and three practitioners in the health and school sectors in Sandnes.

Our focus in this report is the asylum-seeking children under UDI's responsibility. Hence, we have not included unaccompanied asylum-seeking minors who are younger than 15 and under the care of the Norwegian Child welfare services (for a recent evaluation of reception and accommodation of UAM younger than 15 see Deloitte 2014). Initially the project intended to make distinction between war-affected asylum-seeking children based on age, gender, whether accompanied or unaccompanied, whether or not the child was a former child soldier or otherwise affected by war as well as distinguishing between different phases of the asylum process.[8] However, most of these distinctions were seldom addressed by the support systems in the three case countries, and therefore also to a large extent abandoned by the present project. The distinctions that were retained are 1) children in families and unaccompanied asylum-seeking minors and 2) pre-school children and children in school. Some notes are, nevertheless, made related to other characteristics.

2.2.1 Country Cases

The Terms of Reference (ToR) stipulated that the country cases should be selected according to a best-practice criterion as well as to transferability to the Norwegian context. In order to select best-practice countries we reviewed country reports by the UN Committee on the Rights of the Child, but the results were quite alarming: hardly any European country were evaluated as having good practices and support systems in place related to rehabilitation and social reintegration of war-affected asylum-seeking children.

Using the transferability criterion, we selected two of Norway's neighbouring countries, Sweden and Denmark; two countries with quite similar welfare state systems as Norway. The selection of the third case country, Luxembourg, was at the time mainly based on the best-practice criterion as this country was, to our knowledge, the only European country commended by the UN Committee on the Rights of the Child for their improved efforts to fulfil the rights of war-affected asylum children (UN 2007: 3). The transferability to the Norwegian context was also seen to exist as Luxembourg, similar to Norway, is a relatively small and rich European country. It should, however, be noted that later on, in 2013, also Luxembourg were criticized by the Committee; for "lack of available places in special reception centres for unaccompanied children" as well as for not putting in place "a mechanism to identify at an early stage children who may have been involved in armed conflict abroad or been victims of crimes, nor a procedure for their protection, recovery and reintegration (UN 2013: 9).

The country case studies were based on a desk study and qualitative interviews. The *desk study* involved looking for general information, statistics and research studies mainly on websites but also in printed material (see sources). The written material that was analysed

[8] Such as waiting for the Immigration authority's decision, waiting to be settled in a municipality, or waiting to be returned home, here included those unaccompanied asylum-seeking minors who are granted a temporary residence permit.

included legal framework, implementation guidelines or handbooks, documents describing the organization and coordination of interventions, reports, evaluations and studies by NGOs and government institutions, academic research and publications. The documents were mainly collected through the entities that participated in the study, but also through official correspondence to relevant public entities and websites of relevant civil society's organizations.

Interviews were conducted with three categories of respondents: *practitioners, experts* and *war-affected children and parents*. *16 practitioners*, among others social workers, nurses and psychologists who work directly with war-affected asylum-seeking children, were interviewed through this project. These interviews are very valuable as the practitioners are seen as those having the most knowledge about the children's particular needs, challenges and strengths. Five interviews were conducted with *experts* in the field of war-affected children and youth; having either or both research knowledge and practical experience from the field. Experts were purposively selected based on extensive knowledge on interventions aimed to rehabilitate and socially reintegrate war-affected children.

The project also includes interviews with a few war-affected asylum seeking children and parents. Due to ethical reasons regarding parental consent, 15 years was set as minimum age of youth to participate in interviews. To better understand the needs of younger children some parents were also included as interviewees. *Five war-affected youths* and *five parents* of children affected by war were interviewed through this project. Three of the youths were male and two female. Four were UAMs and one was accompanied by her family. The five parents represent three different families; three mothers and two fathers. In addition, we also interviewed three foster parents (two families) of UMs from war-affected countries. Practitioners identified youth and parents that were comfortable to talk about their situation and therefore to participate in an interview. The practitioners used the informed consent document to convey information about the project.

In Denmark, the interviews were conducted with a total of six staff members at the Red Cross head office and at the asylum centres of Avnstrup and Vipperød, with two sets of parents of war-affected asylum children (Avnstrup) and two UAMs (Vipperød). In addition, the study includes an expert interview with Edith Montgomery, Senior Reseacher and Psychologist at DIGNITY - Danish Institute Against Torture.

In Sweden, the interviews were conducted with a total of five practitioners at different public services and at Erikslust PUT Camp (Attendo), with one mother and her daughter at Röstånga ABT (Attendo) and two unaccompanied minors at Erikslust PUT Camp. The Swedish case includes two expert interviews; one with Monica Brendler-Lindqvist, Director of the Red Cross Centre for Torture Victims in Stockholm and one with Guhn Godani, psychologist and psychotherapist at Kris- och traumacentrum also in Stockholm. Both had previously been working for Save the Children Sweden.

In Luxembourg, the interviews were conducted with two staff members at the Luxembourgian first reception centre 'Foyer Don Bosco' run by the Red Cross. Other organizations working with refugees in Luxembourg (OLAI, Caritas, ASTI) were requested for interviews but denied

to have sufficient experiences with war-affected refugee children and referred to the Red Cross. Despite intense efforts, it was not possible to conduct interviews with war-affected asylum children/youths or parents. The Luxembourg case includes an expert interview with René Schlechter, the president of the OmbudsCommittee and Ombudsman for Children's rights.

The interviews were semi-structured, in some cases with practitioners and experts not using the interview guide in a strict manner, in order to allow more flexibility depending on interviewees' particular knowledge and field of expertise.

Due to language barriers, we needed to use interpreters in the interviews with asylum-seeking youth and parents. Staff at the centres and UAM-homes organized interpreters, either from certified interpreter services or among bi-lingual consultants used by the centres. In one interview, there was no availability of an interpreter, and a staff member stepped in to assist during the interview. One interview was conducted with telephone interpretation, while the interpreter was physically present in the others. In most of the interviews, there appeared to be a good dynamic between the interviewer, the interviewee and the interpreter, while more challenges occurred in the interview with phone interpretation. Also the lack of experience with interpretation impacted on the interview that was interpreted by a staff member. We recognize that the risks of misunderstanding are greater as the information has to pass through several steps of interpretation, and although an interpreter allows the interviewees to express themselves in their mother tongue, the interpreter's presence may also have a negative impact on the interview situation. This may be particularly the case for people from war- or conflict-ridden countries and countries with very strict regimes.

2.2.2 Ethical considerations

The data collection was carried out in line with research ethical guidelines developed by The National Committee for Research Ethics in the Social Sciences and the Humanities (NESH), and its research design was approved by the Norwegian Social Science Data Services (NSD). The project was also advised by NESH on the interview participation of minors. Research that includes war-affected asylum-seeking children as interviewees poses more ethical challenges due to the vulnerability of these children than research including interviews with professionals and practitioners. The following section on ethical considerations therefore focuses mainly on issues involving vulnerable children as research participants.

Interviews with minors: Many scholars have highlighted the complexities associated with the recruitment of children as respondents in research projects (Powell & Smith 2009; Curtis et al. 2004; Campbell 2008). The difficulty seems to increase with the marginalization of the given youth category and the sensitivity of the research topic (Powell & Smith 2009). Access to child interviewees is at times *obstructed* by gatekeepers like parents, social workers, teachers, child welfare workers and the like, the motivation often being a wish to protect the child against what they believe could be an uncomfortable situation for the child. At other times, the child him/herself does not *want* to participate. For asylum-seeking children, this could be linked to uncertainty with the asylum case, and the fear that an honest interview with the

researcher could negatively affect their chances of obtaining a residence permit. The difficult transit period may in itself be a reason for not wanting to participate. Lack of confidence in adults in general may be another reason. To avoid that research interviews could be experienced as resembling the asylum interview, interviews were conducted in an informal setting at the UAM-homes/centres, questions were posed in a friendly and sensitive manner and interviewees were well informed about the purpose of the interview.

Although access may be difficult, many children also appear to have a wish to talk about their situation and life conditions, at least as long as the researcher is able to build a relationship of confidence and a comfortable atmosphere of frank exchange and openness. If these conditions are present, research participation can in fact be empowering (Tonheim 2013). Boyden (2000: 2) argues that this is especially the case for "(…) children who have suffered torment and oppression, for the researcher may be the first person to really listen to their problems and take their concerns seriously."

The reasoning for including children as interviewees is, firstly, that we see them as being most knowledgeable about their specific life situation and needs. Secondly, we wish to honour their right to be heard in matters affecting their lives (UN 1989, Art. 12), to be able to voice their opinions on how rehabilitation and social reintegration interventions should be organized and implemented to best meet their needs. We are fully aware that war-affected children are a very heterogeneous group and that their experiences may be quite different. Nonetheless, we still believe that the stories and views of the youths we talked to made a valuable contribution to the project, particularly as it allowed us to better understand their everyday situation.

Informed consent: The project ensured the research sample comprehensive information on the aim of the research, how its results would be used, as well as information on the possibility to refuse to participate, refuse to answer particular questions, and prematurely end the interview if desired. Except for the expert interviews, written informed consents were obtained from all other interviewees. The informed consent document to the youths was written in a child-friendly language and presented both verbally and orally to the child interviewees. As children may find it difficult to understand how the research results can and should be used (Eide 2012), the interviewer therefore assured that child interviewees understood the purpose and the use of the research by asking them questions as to allow them to express their understanding of it in their own words. The interviewer was also sensitive to non-verbal communication and reactions to questions posed in order to interpret whether the interviewee was comfortable or not about his or her participation. In two interviews, where the young person had recently received bad news which clearly impacted on their state of mind, the right to withdraw from the interview was repeated during the interview. However, both chose to complete the interview.

Confidentiality: To preserve the anonymity of respondents is in most type of research considered an ethical prerequisite. This is particularly the case when the research topic is of a sensitive nature. This project therefore guaranteed the children and parents who participate in the project complete confidentiality in the dissemination of results. Before starting the interview participants were informed that if the interview revealed anything that may indicate

child maltreatment or abuse or any other form for criminal activity the researcher would be obliged by law to notify proper authorities (Child welfare services, police etc.). No information which indicated child maltreatment or criminal activity was revealed during interviews.

The informed consent to practitioners informed them that their workplace as well as profession would be mentioned in the dissemination, while their names would not. Expert interviewees, as more public figures, were informed that their viewpoints would be linked to their name, to which they also agreed.

Professional follow-up: There is a risk that the research interview may bring back 'forgotten' and painful memories (flashbacks), particularly if the interviewee normally tends to keep these things locked up inside or has nobody to speak to. Although it may be healthy and release tension to talk, it may also cause the person to relive past sufferings. It was therefore discussed with the practitioners recruiting the child interviewees, in most cases social workers or psychologists, that they would observe whether a follow-up conversation would be necessary. We are not aware of whether such conversations took place or not.

2.2.3 Quality review

Two experts in the field of psychosocial support to war-affected children have reviewed parts of the report. One national expert, Aina Basilier Vaage, reviewed the chapter on the Norwegian context as well as the discussion and the recommendations. Prof. Mike Wessells, a psychologist and an international expert on war-affected children, reviewed the discussion and the recommendations. Inputs from these two reviewers were taken into consideration.

The content and quality of the report was further assured through deliberations and comments by the Reference Group, as well as through a quality review of the whole report done by Prof. Marit Skivenes at the University of Bergen.

3 Lessons from NGOs in the Global South

Although there is quite some material from international and national organisations (both governmental and non-governmental) concerning the support and care for and integration of (unaccompanied) refugee minors in Europe, there is relatively little material specific to refugee children who are victims of war. This is why we here look for *inspiration* resulting from the work of international and local organisations and scholars with long-standing presence and experiences in war-affected areas, in particular related to working with and caring for war-affected children and youth in their home or neighbouring countries. In addition to the particular knowledge here with regards to the target group under study, many of these organisations also have a long history of working with these groups and in these contexts, and their work has often been evaluated extensively, and thus may provide interesting material. The basic difference is that, in our project, children's integration takes place in the destination country (Norway), rather than their country of origin.

3.1 Views on support and care for war-affected children

In many guidelines related to war-affected children, and also in the work of many local, national and international organisations (both governmental as non-governmental), the *rights of the child* and *children's rights* form the overall framework. According to UNICEF (2007b: 5-6)**,** a *child rights-based approach* has no different definition than a *human rights-based approach*:

> In keeping with the outcome document of the UN consultation at Stamford (the UN Common Understanding), a human rights based approach to programming means for UNICEF that:
>
> - The aim of all Country Programmes of Cooperation, including in humanitarian situations, is to further the realisation of the rights of all children and women;
> - Human rights and child rights principles guide programming in all sectors at all phases of the programme process; and
> - Programmes of Cooperation focus on developing the capacities of duty-bearers, at all levels, to meet their obligations to respect, protect and fulfil rights; as well as on developing the capacities of rights-holders to claim their rights.

Many organisations differentiate between several approaches of the support for their target groups. Save the Children mentions three different project approaches (cf. the theory of social ecologies by Bronfenbrenner)**:**

1) *Psychological approach*
2) *Psychosocial approach*
3) *Integrated/holistic approach*

Furthermore, War Child Holland acknowledges two approaches with regard to children in war-affected areas: curative (psychosocial and psychological) and preventive (developmental) (Kalksma-van Lithet et al. 2007). The former aims to help children to dealing with trauma,

while the latter addresses present challenges trying to protect children from future mental and social disorders. In what follows, we shortly describe the most commonly used approaches: *psychological approaches* (also-called *curative* or *trauma-oriented approach*), *psychosocial approaches*, *developmental approaches*, *community-based approaches*, and *integral approaches*.

3.1.1 Psychological approaches

The psychological approach is mainly trauma-oriented, aimed mostly at individual children and utilizes mental health specialists, such as psychiatrists and psychologists, but also other practitioners such as creative therapists. Methods used in this approach include, amongst others, psychotherapy, individual and small group counselling, talk therapy, and creative therapy. Kalksma-van Lithet and colleagues (2007: 8) describe the approach as:

> treatment-oriented and may operate from residential treatment centers, or aim towards capacitating local (mental health) service providers to deliver therapy to traumatised children. Therapists engage in 'longer'-term targeted relationships with their clients to address problems.

Such an approach may be appropriate for children who have either been particularly strongly affected or who suffer from important psychological problems.

Save the Children's *Good Practices Handbook* makes special mention of the possible limitations of individualized approaches and especially trauma-orientated approaches, in particular when the children concerned are only approached in terms of *post-traumatic stress disorder* (Duncan & Arntson 2004). It has been largely shown that approaching war-affected children only from a trauma-related focus is ineffective, in particular in emergency situations such as those in war-affected areas. Other risks in the trauma-oriented approach are visible in that it:

> (…) potentially leads to a focus on an individual's problematic reactions, and directs attention away from the person's strengths, resources and the current context of his or her life, an essential perspective in achieving the broader goal of enhancing psychosocial well-being. Too often such a focus obscures sources of resilience and coping, traditional beliefs, and local resources for healing and providing assistance to children (…). There may be a role for more "intensive" interventions for those most affected; however, they should be culturally appropriate and based on individual's strengths and resources (Duncan & Arntson 2004: 14).

3.1.2 Psychosocial approaches

According to UNICEF, "(…) the term 'psycho-social' underlines the close relationship between the psychological and social effects of armed conflict, one type of effect continually influencing the other" (Legrand 1999: 32). *Psychological effects* refer to those experiences which affect emotions, behaviour, thoughts, memory and learning ability, and the ways a situation may be perceived and understood. The *social effects* of armed conflict include,

amongst other elements, estrangement from family and community as well as possible economic destitution and loss of social status. Psychological assistance to children in need is essential, but psychosocial support to war-affected children is a much broader concept.

The International Committee of the Red Cross (ICRC) identifies three essential conditions for war-affected children's psychosocial well-being:

1) close bonds and relationships with parents or with other caregivers;
2) stability and routines in their daily lives; and
3) protection from harm (ICRC 2011: 16).

3.1.3 Community-based approaches

ICRC places emphasis on a community-based approach whose main aim is to promote children's resilience, i.e. the "(…) ability to 'bounce back' after experiencing a particularly difficult or challenging situation" (ICRC 2011: 16). Such a characteristic is inherent in every person but varies according to its inner strengths and external support structures. An approach based on the concept of resilience implies looking for ways to strengthen the power and abilities that people have, rather than focusing on their weaknesses. The ultimate aim is always to assist people to take care of themselves and of each other (Ibid.: 17). Coping mechanisms employed in the past by a community during a crisis are reviewed and analysed in search of useful examples that can create opportunities to strengthen individuals' and communities' internal and external resources.

Wessells and Monteiro (2006: 129) describes the positive results of a community-based program to improve youths' social integration in post-war Angola, where the strategy was 1) to reinforce key adults' knowledge of youths' psychosocial needs, 2) to improve youths' life skills, and 3) to strengthen youths' positive role in the community. This approach has a complementary focus on youth empowerment and community development.

Quite similar to the community-based approach we find what is called the developmental approach. This approach is advocated and used by War Child Holland, defining it as:

> (…) grounded in the collectivist culture societies of non-Western populations (...). Family and community relations are regarded as key factors that enhance children's coping potential (...). Developmental programmes are future-oriented, geared towards the structural strengthening of children's psychosocial well-being (Kalksma-Van Lith et al., 2007: 7).

Such programmes may include creative exercises, such as drawing and play, while other programmes may focus on children's social environment, aiming to help the children by supporting and informing parents and teachers. Developmental approaches are generally preferable for the following reasons:

- While only a small portion of war-affected communities has serious psychological problems requiring specialised care, the majority of people will benefit from programmes that focus on stress resilience. "The finding that the majority of formerly abducted children (…) did not report psychological symptoms prompts the necessity

of recognizing the necessity of other resources (…), such as individual resilience, coping strategies and supportive networks" (Vindevogel et al., 2012: 325).

- According to a plethora of authors, "(…) western mental health therapy based on trauma and related mental disorders have largely failed in settings with a different cultural context" (Kalksma-Van Lith et al., 2007: 9). An important reason for that is that focus on the individual is not endorsed in non-Western societies. It is also argued that child's confrontation of traumatic events, which is often encouraged in individual therapy, may negatively affect his or her coping mechanisms.
- It is evident from past psychosocial interventions that "(…) children's well-being largely depends on secure family relationships and a predictable environment (...). Social support, social ties, and living in caring environments can be associated with positive mental health outcomes in children and adolescents" (Kalksma-Van Lith et al., 2007: 9).

3.1.4 Integral approaches

According to the guidelines of the *International Interdisciplinary Conference on Rehabilitation and Reintegration of War-Affected Children (2009), best practices* related to reintegration of war-affected children are organized at different levels of interventions:

> "(…) both psychosocial (at the individual level) and structural (at the societal level). In the intervention pyramid four layers can be identified: first, priority attention for large groups is paid to basic services and security, second, community and family support, third, focused and non-specialised support, and fourth, specialised services for a relatively small group required (International Interdisciplinary Conference on Rehabilitation and Reintegration of War-Affected Children, 2009: 3).

Interestingly, in this report *reintegration* "(…) also applies to children and young people who are experiencing 'integration' for the first time*"* as stated in the Kampala Recommendations (War Child Holland & Centre for Children in Vulnerable Situations 2013: 4).

Lastly, as already discussed earlier, *the Paris Principles* provide a comprehensive set of guidance for all concerned with children who have been associated with armed forces and groups (also called former child soldiers) (UNICEF 2007). Next to the mentioned definition of reintegration, the Paris Principles state that the reintegration process should aim to build up the children's self-esteem and independence, and to help them construct a positive life. This can only be achieved through relationships of trust and confidence. Adequate time and resources must therefore be allocated to ensure close and constant cooperation between all participants. Special care must be given to the specific considerations relevant to the children's age and stage of development, gender, and possible disabilities. Further, the principles of action must be based on the needs of the children and those of their families. Programmes must therefore promote the best interest of the child. Any (re)integration effort related to children in vulnerable situations, must be in accordance with *child rights*.

3.2 Programming

Next to these overall principles that are thought to be necessary to underpin support for war-affected children in these particular contexts, we here also want to shortly describe some specific programmes that have been set up for war-affected children in conflict and post-conflict contexts. These programmes, together with their overarching principles as mentioned above, can give interesting inspiration on how to realize rehabilitation programmes for war-affected children living in host countries, far from their home country.

UNICEF, in accordance with the above-mentioned *psychosocial approaches,* stresses the need for *psychosocial* programming, as opposed to only focusing on (war-related) trauma. Their program consists of "(…) structured activities designed to advance children's psychological and social development and to strengthen protective factors that limit the effects of adverse influences" (UNICEF 2007b: 32). In this frame, recreational activities are of great importance. Apart from reclaiming a basic children's right, they play a part in the healing process, contribute to the children's psychosocial well-being and facilitate the reconciliation process. In addition to trained personnel, family or other significant adult caregivers can play an important role, and their capacity to care for and protect the child should be developed and supported (Ibid.: 30).

Based on the experience of past interventions in war-affected areas, ICRC identifies a number of factors as being crucial to the success of psychosocial support programmes (ICRC 2011: 17):

- *Children's participation*: Children should be involved as much as possible in all aspects of the programmes. ICRC has successfully involved them in planning, implementing, monitoring and evaluating and even reporting on programmes. Participating children are given the chance to develop a variety of competences. Their involvement also increases their self-confidence and improves their communication skills; most importantly, it shows that their opinions are respected and their importance to society is recognized.
- *Involvement of parents/caregivers* to provide children with an external resource.
- *School-based approach*: ICRC stresses the need for a holistic approach, one that combines psychosocial support and education.
- *Contextualized responses*: Interventions must be well-suited to the specific situation, rather than implementing general principles. Special care must be given to ensure that all activities are culturally appropriate.
- *Flexibility*: Any standardized approaches generated must be able to adapt to different ethnic and cultural contexts as well as evolve according to changing situations.
- *Layman's approach*: The layman's approach to counselling is one that builds on community resources and may complement the professional one. Members of the community can be trained to help, when such an organized community exists in the destination country. This approach has its limitation, so effective referral mechanisms must be available.

- *Training volunteers*: ICRC places great value on volunteer support. But volunteers are sometimes hesitant to engage in counselling because they are afraid of doing harm, or simply do not know how to react to the difficult stories children tell them. In case volunteers are used, on-going training and continuous follow-up and supervision is necessary. This may be costly and time-consuming but nevertheless necessary, since if helpers themselves are not well it will affect the beneficiaries and lower the quality of the service provided, thus potentially endangering the project.

Some valuable lessons learned by Save The Children are the following (Duncan & Arntson 2004:11), firstly, that interventions can focus on decreasing an individual's exposure to risk or adversity, but at the same time also increasing the individual's internal resources, and mobilizing protective processes in the social world that surrounds individuals. Secondly, that potential risks, vulnerabilities, assets, and protective factors exist in all people, families, communities, and societies and these must thus be recognized and taken into account. Further, assessments of individual children need to include competence, assets, strengths, and protective factors along with symptoms, problems, risks, deficiencies, and vulnerabilities. Children can show remarkable resilience provided that certain key resources and protective systems are preserved or restored.

According to Save the Children's *Good Practices Handbook* "(…) structured activities are an essential first step to normalize life, aid emotional and social integration, and reduce idleness" (Duncan & Arntson 2004: 14). Parent participation is encouraged, and older children are encouraged to assume a leadership role in providing assistance to the younger ones. Furthermore, special care must be taken to ensure that interventions are culturally appropriate. The designer of such interventions must understand and truly respect relevant beliefs and practices in a given setting. All cultures contain valuable insights on how to better help children and those must not be ignored. Participation of the people, including children, in all stages of the program, including the planning and evaluation of the activities, will help to ensure both cultural relevance and sustainability, as well as to empower them. Protective factors that enhance children's resilience include family ties, connection to competent caring members of one's own cultural group, educational and economic opportunities, participation in familiar routines, and connections to faith and religious groups.

Next to these programme elements focussing on an integral and/or psychosocial approach, different organisations, amongst which War Child Holland, have proposed methods that can be classified as curative/psychological, including:

1) Psychotherapy (featuring a mental health professional working with an individual or small group);
2) Creative therapy (which is based on creative exercises such as drawing or drama);
3) Psychomotor therapy (which uses adapted body experiences, movement and sports situations);
4) Self-help groups of children with similar problems trying to help each other; and

5) Counselling, in which professionals offer analytical and problem-solving skills to children with psychosocial problems. Counselling may be conducted in an individual, group or family setting (Kalksma-van Lith et al. 2007: 8).

Further, a distinction is made between working in groups and methods working with individual children. It is hereby said that in psychosocial interventions – in contrast with most trauma-related (psychotherapeutic) approaches, the work is mostly done by facilitators (ideally community members) in a group, rather than an individual setting. Sessions "(…) focus on the exploration of the surrounding world, strengthening cognitive, emotional and social skills, through imitation, competition, cooperation, fantasy, etc." (Kalksma-van Lith et al. 2007: 11). The methods used here can be either creative or recreational. Creative group methods aim to address children's psychosocial development, and strengthen protective factors, by providing children with physical, emotional and social skills, helping them to express emotions, communicate and build relationships. Examples of creative activities are music and dance, art activities, drama and storytelling, and sports and games (the latter can also be viewed as recreational). Recreational group methods may indirectly contribute to the psychosocial development of children, but mostly provide children with moments of relaxation and may therefore have a healing effect (Ibid.: 12). Relevant activities include play days, festivals and community events.

A good overview of psychosocial support activities that can be used when working with war-affected children, in particular former child soldiers, in (post-)conflict contexts is provided in the article *Psychosocial care in rehabilitation centers for former child soldiers in Northern Uganda* (Coppens et al. 2000: 329, 345). Such activities may include:

1) *Group counselling*:
   - drawing, as an indirect way of learning what is disturbing the children
   - debate - to practice communication skills, critical thinking, problem solving
   - role play/drama "a useful technique for children who are not able to talk about their experiences"
   - news analysis
2) *Storytelling*: Children learn about what others do to make them feel better (or to heal) and realize that other children underwent the same experiences
3) *Guest speakers*; broaden the children's horizons and familiarize with different people and opinions
4) *Videos* (educational or recreational)
5) *Recreational activities* (children's participation in these activities is considered a sign of reduced trauma):
   - Sports and games: stress release, social interaction, integration (when involving the community)
   - Music and dance: to reduce the level of stress
6) *Religious education/prayer*: Praying provides emotional support, encourages healing and enables children to keep faith in the future

7) *Visiting* (university, important places): for educational purposes and orient children to the future.

This article also mentions some overall lessons learned from rehabilitation centres for former child soldiers in Northern Uganda, hereby identifying some good and bad practices (Ibid.: 353). Examples of good practices are: involving family and community members; implementing culturally appropriate activities (e.g., traditional dances); ensitizing family & community to the plight of former abducted children; providing support to formerly abducted children and other vulnerable children; providing of educational support & vocational training to earn an income; and community-based support. On the other hand, some common mistakes are: making promises you can't keep (thus endangering trust); staff getting too much involved in the job (healthcare providers working with traumatized children may suffer from compassion fatigue); and not following-up the children after they have left the institution or the program.

One approach both UNICEF and Save the Children deemed being unacceptable as a long-term solution is institutionalization: centres and orphanages for unaccompanied children have been used extensively in the past, and said to having failed to provide adequate childcare (Duncan & Arntson 2004: 5).

3.3 Particular groups

Many organisations and scholars stress that support and care for war-affected children and adolescents should be flexible and heterogeneous enough to meet the diversity of needs of the children involved. Hereby, there is often a plea to pay specific attention to particular groups of children. We, therefore, briefly discuss some aspects in relation to the group of female war-affected children, and to unaccompanied children.

3.3.1 Girls

While most of what was mentioned regarding war-affected children in general also applies to girls, there are particular considerations regarding their own experiences as possible victims of gender-based discrimination or even rape. According to Save the Children "(…) girls frequently want support to be offered in ways that do not single them out as former children associated with armed forces and groups or survivors of rape" (MacVeigh et al. 2007: 25). Teenage mothers may resent being treated as children, and want to be treated like adults with the respect and responsibilities stemming from their situation. Given the similarities between them and other marginalised girls and underage mothers, the opportunity arises for inclusive programming. Girls coming from countries where female genital mutilation is commonly practiced may require intervention and health education from health authorities with specific knowledge of that issue. Education on reproductive health in general, family planning, abortion laws and information on available services is also desirable. In any occasion, care

should be taken that psychosocial programming is, in the context of their culture, gender appropriate.

3.3.2 Unaccompanied children

War can lead to temporary or permanent separation of children from their parents or other adult caregivers and this separation can have a devastating social and psychological impact (Machel 1996). It is essential that unaccompanied minors are identified immediately after their arrival, because while they are usually taken care of by other refugees, experience shows that physical and developmental needs are not always met. These children require monitoring to make sure that their needs are being met. Secondly, tracing for parents and other relatives must begin as soon as possible. Then interventions can be designed that build upon protective factors to enhance the child's internal resources, since they need a way of coping with the separation from their family. These interventions must be tailored towards the needs of the individual children. Therefore, we need to take account of the child's individual and familial circumstances, including his/her psychological and physical health, the situation in the country of origin, and, thirdly, the child's level of integration in the host country.

After having identified separated children, the next step should be to appointing an independent guardian or adviser to ensure that all decisions taken are in the child's best interests, that the child has suitable care, accommodation, education, legal support and health care provision, to consult with and advise the child, and to contribute to a durable, long-term solution. The appointment of guardians/ advisers should be made within one month after the child's notification to the relevant authorities (Save the Children & UNHCR 2004: 16). Those professionals may have diverse backgrounds, but they all need child-specific care expertise, and an understanding of the special and cultural needs of separated children.

UNHCR has published its *Guidelines on Policies and Procedures in dealing with Unaccompanied Children Seeking Asylum* (UNHCR 1997). In 2005, UNHCR Greece in cooperation with the Greek Ombudsman department of children's rights modified and summarized them in the following eleven points (UNHCR/Συνήγορος του Πολίτη 2005: 2-3):

1. Best interest of the child: In each decision the best interest of the child must be taken under consideration.
2. Non-discrimination: Unaccompanied children asylum seekers should enjoy equal treatment and equal rights with children - citizens of the host country.
3. Participation in decision making: Depending on the age and the maturity of the child, his/her opinions must be taken under consideration in any decision making
4. Respect of their cultural identity: All services provided to the children must respect their cultural identity, including preservation of their cultural background, mother language and religion.
5. Interpretation: Interpreters should be available during any kind of contact with children. When possible, interpreters should be skilled and trained in refugee and children's issues.

6. Confidentiality: Care must be taken that information sought and shared for one purpose is not inappropriately used for another purpose causing potential harm to the children or their families.
7. Information sharing: Information about their rights, the available services in which they can have access during their asylum request as well as the current situation in their country of origin and the efforts to locate their families must be provided to unaccompanied minors asylum seekers.
8. Cooperation between relevant authorities and NGO's: The close cooperation of a variety of government bodies, specialised agencies and individuals in delivering an effective continuum or care is crucial.
9. Staff training: It is desirable that agencies dealing with unaccompanied children establish special recruitment practices and training schemes, so as to ensure that persons that will assume responsibilities for the care of the children understand their needs and possess the necessary skills to help them in the most effective way
10. Durable solutions: All decisions taken for the protection of unaccompanied children must take under consideration their long-term interests and their well-being.
11. Speedy decision making: In recognition of the particular vulnerability of unaccompanied children, every effort should be made to ensure that decisions relating to them are taken and implemented without any undue delays.

4 Case Studies: Denmark, Sweden, Luxembourg

The following chapter presents three country cases selected for this project in order to assess measures for rehabilitation and reintegration of war-affected children in other European countries. Through qualitative interviews mainly in Denmark and Sweden, but also in Luxembourg and desk studies on the three countries, we identified interesting psychosocial measures and interventions that have relevance also for the Norwegian context and might inspire Norwegian stakeholders in this field.

4.1 Statistics

There are variations in the asylum-seeking population in Norway, Denmark, Sweden and Luxembourg. These variations are related to total numbers of applicants, from which countries the asylum applicants come and outcomes of asylum applications. Sweden is by far the country with the highest number of asylum applicants per million inhabitants, almost 2 000 per million inhabitant (Eurostat, 2014). Luxembourg also receives a large influx of asylum seekers relative to the size of its population (in 1999 higher than any country in the EU). On the other hand, similarly to Norway, "(…) relative to its wealth […] Luxembourg shoulders a far smaller proportion of the refugee burden**"** (Ingleby & Kramer 2012: 3)**.** Table 1 shows the five main countries of origin and the total number of asylum applicants received by the three case countries and Norway in 2013.

Table 1 - Five main citizenships of asylum applicants, 2013

Norway			**Denmark**			**Sweden**			**Luxembourg**		
Eritrea	3,250	27%	Syria	1,685	23%	Syria	16,540	30%	Kosovo	160	15%
Somalia	1,695	14%	Russia	965	13%	Stateless	6885	13%	Bosnia Hercegovina	145	14%
Syria	865	7%	Somalia	920	13%	Eritrea	4880	9%	Montenegro	115	11%
Afghanistan	725	6%	Serbia	465	7%	Somalia	3940	7%	Albania	75	7%
Sudan	600	5%	Afghanistan	410	6%	Afghanistan	3025	6%	Serbia	60	6%
Other	4,795	40%	Other	2,720	38%	Other	19,000	35%	Other	515	48%
Total	11,930		Total	7,165		Total	54,270		Total	1,070	

Source: Eurostat (2014) Asylum applicants and first instance decisions on asylum applications: 2013. Population and social conditions, Data in focus 3/2014.

Children may seek asylum either together with their parents or as unaccompanied minors. Table 2 shows the total number of child applicants irrespective of whether they were accompanied or not.

Table 2 - Child applicants, 2013

	Total (including adults)	0-13	14-17
Norway	11,930	13,5%	9,1%
Denmark	7,165	20,3%	8,4%
Sweden	54,270	21,2%	9,5%
Luxembourg	1,070	16,6%	7,7%

Source: Eurostat (2014) Asylum applicants and first instance decisions on asylum applications: 2013. Population and social conditions, Data in focus 3/2014.

Variations are also seen in asylum application outcomes. Sweden has the highest rates of granting asylum, followed by Norway and Denmark. Luxembourg, on the other hand, rejects about 90% of its asylum applicants. This should, however, be linked to the fact that the numbers of asylum seekers coming from countries currently affected by war or armed conflict are low in Luxembourg in comparison to Norway, Sweden and Denmark.

Table 2. - First instance decisions[9] by outcome, 2013*

	Total	Positive outcome		Rejected	
Norway	11785	5770	49%	6015	51%
Denmark	6965	2810	40,3%	4155	59,7%
Sweden	45005	24015	53,4%	20990	46,6%
Luxembourg	1245	130	10,4%	1115	89,6%

Source: Eurostat (2014) Asylum applicants and first instance decisions on asylum applications: 2013. Population and social conditions, Data in focus 3/2014.

* Note: The year in which the application is submitted is not necessarily the same year as the application is granted or denied.

4.2 Incorporation of the Convention on the Rights of the Child

Norway has, as have all the case countries in this study (Denmark, Sweden and Luxembourg), ratified both the CRC and the Optional Protocol regarding children involved in armed conflict. Unlike Denmark, Sweden and Luxembourg, Norway incorporated the CRC and the Convention's two protocols[10] into the Norwegian legislation in 2003, granting the Convention precedence over other Norwegian legislation in case of conflict (the Norwegian Human Rights Act, section 2). Both Sweden and Denmark did not find it necessary to incorporate the CRC, as they viewed their national legislation already in harmony with the Convention. However, both countries have to a varying degree incorporated parts of the CRC, particularly

[9] First instance decision means the first handling of a case. Asylum-seekers might complain and have their case reviewed, which will then be the second instance decision.

[10] The Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict (UN 2000a) and The Optional Protocol on the sale of children, child prostitution and child pornography (2000) (UN 2000a and 2000b)

Article 3 on the child's best interest and Article 12 on the child's right to be heard and its points of view considered (Lundy et al. 2012). Luxembourg included "(…) the principle of the best interests of the child" into the Act of 16 December 2008 on support for children and the family, but the UN Committee is concerned about the "lack of adequate guidelines and procedures for implementing the right of the child to have his or her best interests taken as a primary consideration in actual practice and throughout all State party institutions, bodies, policies and programmes" (UN 2013: 4)

The child's best interest is the overarching principle that should guide every procedure and decision-making that affects a child's life. When determining the best interests of the child, all the rights set forth in the CRC need to be taken into consideration (UNHCR 2008: 15). The CRC, moreover, declares that states do not have the authority to discriminate between asylum-seeking and other children when asylum-seeking children reside in the country. This follows from Article 2 (1): "States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind." In the case of Luxembourg, the UN Committee regrets, in the concluding observations on the implementation of the Convention on the Rights of the Child, that the State party still maintains its reservations to this article and others, *"which seem incompatible with the object and purpose of the Convention"* and is *"concerned about the absence of a comprehensive policy on children in the State party and of a comprehensive strategy for implementing the Convention as a whole"* (UN 2013: 3).

4.3 Ownership and Organization

Denmark

The Danish Immigration Service (Udlændingestyrelsen) is responsible for providing accommodation at asylum centres in co-operation with several partners who are responsible for the day-to-day operation of the asylum centres. The main operator is the Danish Red Cross which at the time of the fieldwork runs 13 asylum centres. The municipalities of Jammerbugt, Thisted, Vesthimmerlands and Langeland run their own asylum centres, while the centre in Bornholm (Centre Rønne) is run by the Danish Red Cross and Bornholm regional municipality in partnership. [11] The Danish case study is limited to investigating the organization and workings of the Danish Red Cross.

In Denmark, recently arrived asylum seekers stay in *reception centres*. *Accommodation centres* are for asylum seekers whose applications are being processed, and *departure centres* are for asylum seekers with a final rejection of their application. *Special accommodation centres* are provided for unaccompanied children seeking asylum and asylum seekers with special needs for care, such as in the case of severe illness (New to Denmark. The official Portal for Foreigners 2014). As of October 2014, there was one reception centre (Vipperød) and one accommodation centre (Gribskov) for UAMs. There was also an accommodation centre only for single women with or without children (Kvindeafdelingen), but other families

[11] As of October 2014.

with children were mixed with single men and women in reception, accommodation and departure centres.

Health clinics, schools, kindergarten, children's and youth's clubs are established linked to the different asylum centres. These services are operated by Red Cross staff members and only available to asylum seekers living at the centres. A small number of children attend public schools. In Bornholm, where the asylum centre is run jointly by Red Cross and the regional municipality, the municipality is responsible for leisure activities, kindergarten and schooling for children, while the Red Cross is responsible for the daily operation of the centre and healthcare, education and leisure activities for adults.

Danish Red Cross has a Psychological Unit located in Copenhagen at the head office but serving the centres throughout the country. One sub-unit is the Child Psychological Unit which is responsible for the psychological screening and therapy aimed at children. According to the contract with the Danish Immigration Service, Red Cross is free to use subcontractors when it comes to schooling and health services.

Sweden

In Sweden the Migration Board (Migrasjonsverket) is the government structure responsible for the reception of asylum seekers. Unaccompanied minors are placed directly in the municipalities which are responsible for their everyday life and support. The Migration Board has *accommodation centres* and *flats* available for families with children as well as single asylum seekers (Migrationsverket 2014). However, the largest responsibility to receive, accommodate and care for asylum seekers lies with the 21 autonomous county councils and the 290 independent municipalities.[12] Both the Migration Board and the municipalities may use sub-contractors to run the accommodation facilities. Attendo is, for instance, operating 20 transit and accommodation centres, some on behalf of the Migration Board and some on behalf of municipalities (Attendo 2014). The Swedish case study is limited to investigating the organization and workings of two housing facilities in Malmø run by Attendo.

Asylum-seeking children have the same rights to medical care, dental care and schooling as other children in the Swedish society. These services are provided by the relevant public structures. The organization in Sweden is, in other words, based on *sector responsibility*. The *municipalities* are responsible for preschools (kindergarten) and schools. *County councils* are responsible for health and dental care. Medical care is provided through primary health care structures. However, in Malmö there is a *Refugee Health Centre* with nurses and doctors that provide asylum seekers medical advice and necessary treatment.

Luxembourg

Luxembourg Reception and Integration Agency (OLAI) was created in 2008 and has replaced the Government Commission for Foreigners (CGE) (MEMORIAL 2008: Loi du 16 décembre). The measures of the new reception and integration policy entered into force on 1 June 2009. The OLAI is an administration established within the Ministry of Family and Integration and the reason for its establishment was first and foremost to improve integration:

[12] Email from Socialstyrelsen.

> This new administration was set up following the Declaration of 4 August 2004 in which the Government affirmed its will to integrate non-Luxembourgers into Luxembourger society and to avoid the creation of parallel societies. The evolution of immigration and the demographic prospects in the Grand Duchy of Luxembourg have led the Government to reform legislation on the issue. It has set up an effective policy that is adapted to current realities and in which integration is understood as a mutual process of involvement by the foreigner and the host society (OLAI 2014).

OLAI's mission is to implement and coordinate the Government's reception and integration policy, facilitate foreigners' integration process, fight against discrimination, study migration flows, provide support to applicants for international protection and manage *accommodation centres* (OLAI 2011a). OLAI is divided according to its remits into several departments: Social Services, Reception, Integration, Accommodation, Accounting, and the Technical Department (OLAI 2011b). The Agency is also in charge of providing support and supervision to asylum seekers. Asylum seekers fill a request for International Protection at the Immigration Office of the Ministry of Foreign Affairs (Division de l'Immigration du Ministère des Affaires étrangères), and then meet a social worker detached by the OLAI who will explain their rights and obligations in Luxembourg (OLAI 2011c).

4.3.1 Interdisciplinary and intersectoral cooperation

In the *Guidelines on Policies and Procedures in dealing with Unaccompanied Children Seeking Asylum* an interdisciplinary and intersectoral cooperation is strongly recommended:

> Authorities, schools, organizations, care institutions and individuals involved in the care of the unaccompanied refugee child in the community, should co-ordinate their efforts to keep to a minimum the number of different official entities with which the child is in contact (UNHCR 1997, Art. 10.2).

Denmark

The organisation of the Danish Red Cross' work related to asylum seeking adults and children bodes well for interdisciplinary cooperation. When there is a concern about a child's well-being, parents/legal guardian and professionals involved in the child's life sit down for an interdisciplinary meeting to discuss the situation and how to improve it. The professionals that participate in such meetings are the teacher or preschool teacher, the nurse and/or the doctor, the social curator at the centre or the contact person of unaccompanied minors, and the child's caseworker at the Social Services. If other support professionals (a child psychologist or other kinds of therapists) are involved they will also attend this interdisciplinary meeting. In this joint meeting decisions will be made as to how the child should be supported in the different sectors involved (the centre, the clinic, the school/kindergarten, the home etc.). The child's caseworker at the Social Services as well as staff at asylum centres and UAM-homes are both central to establish the intersectoral cooperation.

Sweden

As noted above, the organization of services and support to asylum seekers in Sweden is based on *sector responsibility.* There is, nonetheless, some interdisciplinary cooperation. This was, for instance, seen in the care of UAMs, where staff at the HVB-home, particularly the

UAM's contact person, would establish contact with the minor's custodian/representative or caseworker at the Social Service in case of any special difficulties at home or at school. The municipality of Skellefteå is a good example from Sweden where the municipality has been able to establish a successful cooperation and engagement by different public sectors, NGOs and the grassroots level. The successfulness of interdisciplinary and intersectoral cooperation varies, however, across municipalities.

Luxembourg

Although administrative procedures and cooperation among different bodies is easier to put in place in small countries than in larger ones, we find challenges also in Luxembourg. A report from 2010 notes communication problems between both civil society organisations and the state, as well as between different ministries, in particularly the Ministry of Immigration and the Ministry of Family (Wurth 2011). However, there are examples of good interdisciplinary cooperation within sectors. The best example is the interdisciplinary and cross-culturally sensitive psychological support project called *Eng Bréck no baussen* (this measure will be described in detail under *Good practices regarding Psychological support*). The project is run by the Red Cross Luxembourg and aims at offering and organizing mental health support and care to asylum seekers. In this project the Red Cross psychologist works in close cooperation with doctors, psychiatrists and associations providing support for people with mental health problems.

4.3.2 Civil society participation

Denmark

Danish NGOs, for instance Save the Children Denmark and the Danish Refugee Council, play an important role in providing volunteer programs with activities such as homework assistance, language training, network/support families and leisure activities. Activities take place either at the asylum centres or in the local community. The Danish Refugee Council (DRC) alone provides a network of 5000 volunteers. DRC stands out as an NGO with a great level of competence and involvement related to the situation of asylum seekers. In addition to the volunteer programs they run a competence centre for vulnerable refugees (Centre for Udsatte Flygtninge) where professionals that encounter refugees with traumas may seek assistance and advice. However, the most important NGO related to asylum seeking children is the Danish Red Cross. The Red Cross has had the task of accommodating asylum seekers since 1984 and operates the majority of the asylum centres. Linked to the asylum centres they have established clinics, schools and day care centres, and their volunteer program exceeds those of other Danish NGOs with a crew of about 20.000 volunteers.

Sweden

NGO's, such as Save the Children, are organizing activities and programs for asylum-seeking children in Sweden. Whether or not children take advantage of such possibilities may, however, vary. At the time of the fieldwork there was no close contact between the residence facilities of Erikslust and Röstånga and NGOs offering recreational activities. It is likely that staff at the residence may play a crucial role in both inviting organisations to their facilities or

otherwise contact them to get information about what activities they offered and by motivating the asylum-seeking children to participate in such activities.

Luxembourg
Also the practitioners in the first reception centre in Luxembourg related that groups of volunteers participate in the support for the newly arrived asylum seeking children, e.g. offering weekly leisure activities, reading groups etc., which are willingly frequented by the kids.

4.4 Accommodation

Several aspects related to housing were highlighted by interviewees as important to the psychosocial well-being of all asylum-seeking children. The main aspects are 1) privacy and the general standard of living (particularly when it comes to size of the accommodation facility), 2) that families with children must live at the same centres and share a kitchen and bathroom with a large number of single men, 3) the number of residents at each facility (particularly the case in Denmark), and 4) the number of relocations.

4.4.1 Children in asylum-seeking families

Denmark
The centres visited in Denmark are marked by the recent and unforeseen increase in asylum seekers. Avnstrup hosted about 800 persons at the time of the fieldwork, while one informant noted that about 300 residents would have been optimal. The 2014 contract between the Migration Board and the Danish Red Cross also underlines that the number of residents should be reduced (from 550 to 500) during 2014 (Utländingsstyrelsen 2014: 5). However, due to the recent increase in asylum seekers the opposite had happened. Sweden has also recently experienced an increase in asylum seekers putting a pressure on accommodation facilities here as well.

A study of the *Living conditions for children with families in Danish asylum centres* (Christensen & Andersen 2006), reported that the daily life of children in the Danish asylum centres was characterized by limited space and frequent relocations and broken social relationships. This report led to a change in the Danish system where families with children were now to have two rooms per family. This was also a response to the Danish Red Cross Asylum Department's desire to improve conditions for families (Seidenfaden 2009). According to the website of the Danish Red Cross, each asylum family should generally have two rooms and a private kitchen and bathroom, but this is clearly not always the case. Interviews at Avnstrup reveal that many families have to share kitchen and bathroom with other residents at the centre. Families normally had one room. Interviewed parents at both centres voiced worries and stress related to sharing a kitchen and bathroom with a large number of single men. They were particularly worried about their daughters.

Both in Denmark and Sweden asylum seekers are allowed to live outside the asylum centres. However, while this opportunity is given all newly arrived asylum seekers in Sweden, in the

Danish system private housing is only allowed on certain conditions. After six months at a centre, asylum seekers may apply to the Danish Immigration Service for permission to move into their own homes, which the Red Cross helps them find. It is also possible to rent self-financed residences or to be accommodated by relatives who reside legally in Denmark. The possibility to live outside an asylum centre is particularly aimed at families with children or asylum seekers with health issues or personal problems, "(…) whose general situation is strengthened most effectively by moving into an independent residence" (New to Denmark. The official Portal for Foreigners 2013a). The general precondition to live outside the centre is to contribute with information while the asylum case is being processed and participate in the return to country of origin if the case is rejected.

A small group of asylum seekers who for psychosocial reasons have special needs to live outside the centres – for instance families with children - live in so-called special residences. These are affiliated with an asylum centre, and one must have lived one year at the centre before applying. This option is most often for families with children who have had their asylum application rejected (interview with social worker). The precondition assisting the authorities in the deportation process does not apply to these families. As stated at the website *New to Denmark* "(…) the purpose is to give these families the opportunity to have more normal conditions for the daily life of the family for a period of time, especially for the sake of the children, as this can also strengthen the family before departure to their homeland" (New to Denmark. The official Portal for Foreigners 2013b). Families living in special residences have the same obligations and rights as other rejected asylum seekers (Seidenfaden 2009: 8).

Sweden

From 1994 it became possible for asylum seekers in Sweden to organize their own accommodation while continuing to receive financial compensation from the Migration Board (Rättsnätet 1994). The Migration Board is responsible for providing accommodation for asylum seekers who do not choose to arrange accommodation on their own. Most of the accommodation facilities provided by the Swedish Migration Board consist of apartments in ordinary residential areas. Families may get their own room but must expect to share an apartment with other people. This accommodation option is characterized by cramped living conditions and low standards, and sometimes also by conflicts as families from different cultural and religious backgrounds are placed together in one flat (Boverket 2008).

About 60 % of the asylum seekers in Sweden choose to rent their own flat or to live with relatives or friends already living in Sweden (SOU 2009:66). The only thing the state requires if asylum seekers choose private accommodation during the asylum period is that they can provide an address where they may be reached. The termination in 2005 of housing allowance to people with their own accommodation (Regeringen 2004:28) has not had any noticeable effect on the number of asylum seekers choosing to live privately (SOU 2009:129). This accommodation option is also characterized by cramped living conditions. According to the study of Lennartson (2007), almost none of the children have their own room, and no quiet space to do homework and play. The Swedish Migration Board has only an address where

they can reach the asylum seeker and do not have any control or say with regards to the standard of the accommodation.

There are several factors that impact on asylum seekers choices related to accommodation. These factors are also linked to the psychosocial wellbeing of both adults and children in the family. Firstly, many asylum seekers are yearning for normalcy, self-determination and control. Asylum seekers want to be integrated, to have social contact and feel involved in the local community (SOU 2009:132). Secondly, asylum seekers have a desire to stay with or close to family and other countrymen (SOU 2003:75). Thirdly, there are negative perceptions among asylum seekers of the Swedish Migration Board's accommodation facilities. The one family interviewed in Sweden lived in a transit centre, had one room and was, at that time, the only family at the centre (interview with mother and daughter), creating a situation where the children had no peers to be with. Factors like geographical location, often far from a vibrant labour market, and low standard, especially cramped conditions associated with residence facilities, are underlined as important reasons why asylum seekers choose private accommodation (see Boverket 2008; Lennartson 2007). It's reassuring to come to people who know how society works, and who can speak the language (Boverket 2008). That the asylum seekers have people around them who can help them is also a relief to the caseworker at the Swedish Migration Board:

> For the children it can be good to have adults around who are not so pressured by anticipation of their asylum decision. But for most people that we have interviewed, the positive this housing arrangement becomes subordinate to the view that children are having difficulties living under so unsafe conditions (Boverket 2008: 22).

The downsides to such private accommodation are, among other things, that it is more difficult to reach asylum seekers, for instance with regards to health screening and schooling and that particular areas become overpopulated with immigrants and asylum seekers which may cause segregation rather than integration (SOU 2003:75).[13]

Luxembourg

OLAI is responsible for the accommodation of asylum seekers in Luxembourg. During the asylum seeking process, the accommodation of asylum seekers is provided by the state for any person who does not have sufficient means to provide one for him or herself. The accommodation can be provided in public or private housing structures, hotels, private centres or other adequate units. Whenever possible, the OLAI ensures that family unity is maintained. That is, all persons who depend on the same application for international protection or who arrived in Luxembourg together, should live in the same housing facilities.

OLAI provides the accommodation at asylum reception centres in co-operation with the Red Cross and Caritas. As Luxembourg is a small country, there are only a few asylum centres. Most housing is directly managed by the OLAI Accommodation Department. Some are managed by the Luxembourg Red Cross and Caritas Luxembourg (Foyer St-Antoine, Centre

[13]As this study/mapping only deals with asylum seeking children (and families) yet to receive a residence permit we will not include how housing arrangements may impact on integration later on.

OASIS).[14] The Luxembourg case study is limited to investigating the organization and workings of the Red Cross, as the other organizations stated to have little or no experiences with war-affected asylum children.

The Red Cross currently manages four accommodation centres for asylum seekers in Luxembourg: *The first reception centre (Centre de Premier Accueil) Don Bosco at Luxembourg/Limpertsberg***:** All migrants who apply for international protection are immediately directed to the Red-Cross-run First reception centre Don Bosco, located in the capital. This centre is the only first reception centre in Luxembourg, and it also serves as an emergency shelter for recently arrived migrants who cannot immediately access the refugee office of the Ministry of Foreign Affairs, which is in charge of international protection applications (e.g. during the week-ends). The centre can accommodate around 150 people. During the interviews with the staff members, around 140 persons were accommodated there. The program for the installation of individual networks for psychological and psychiatric support is located here (see above). Generally, the applicants for international protection stay at the Don Bosco centre as short a time as possible (up to maximum three months), then most of them are accommodated in various accommodation centres throughout the country, while their applications are being processed.

*The foyer d'accueil – Luxembourg/Eich***:** The residents of this centre are exclusively families and unaccompanied minors. About 60 persons, including 14 families and 5 unaccompanied minors, live there at the time of the research. Refugees with special needs (e.g. people with physical or psychological health problems, single-parent families with educational difficulties, etc.) are prioritized. Also refugees coming to Luxembourg through a governmental relocation program can be accommodated in Eich. The centre offers better conditions than most reception centres, with individual studios and a large outside garden. There are educational, cultural, and leisure activities for the residents. A team of Pax Christi volunteers organizes school help, while Red Cross volunteers support the service team with its work.

*The foyer d'accueil Félix Schroeder – Rédange***:** The house in Rédange accommodates up to 50 people**.** It is exclusively meant for single women and mothers with young children**.** Collaborations with different local associations have been put into place. Thanks to a hotline, the social team remains reachable outside of office hours. Different socio-educational and cultural activities as well as different informational meetings are held at this shelter (Croix-rouge Luxembourgeoise 2014).

The foyer d'accueil in Betzdorf: This is a very small centre and currently three families are located there.

Concerning other centres, the Ombuds man for child's rights expresses his concerns, that the conditions for children are not adequate. Generally, they don't have a room of their own, and they don't even have a quiet place to do their school homework .

[14] http://www.olai.public.lu/en/accueil-integration/encadrement/hebergement/

4.4.2 Frequent relocations of children in families

Whether living in asylum centres or with family or friends, many asylum seeking children experience that their family has to move several times during the case procedure. Moving may be linked to the desire to avoid becoming a burden to friends and family members, either financially or with regards to limited space (Hadodo & Åkerlund 2004; Brekke 2004, referred to in Boverket 2008). Caseworkers at the Migration Board in Malmö interviewed by Boverket (2008) are of the opinion that families move more frequently than single people, as it is more difficult to take in a whole family for a long time than a single person who may sleep on the couch. For those living in asylum centres, relocations are linked to the need of state authorities and municipalities to move asylum seekers around due to the constantly changing numbers of asylum seekers. According to interviewees, relocations tend to increase in frequency when the asylum system is under pressure as was the case in both Sweden and Denmark at the time of the fieldwork. As an example of relocations: The families that participate in the Special residence project of the Danish Red Cross had moved between 5 and 14 times between asylum centres in Denmark (the families' own data) during their years in Denmark (between 7-11 years) (Seidenfaden 2009: 8). According to interviews, psychologists or social curators at the Danish Red Cross write to the Danish Migration Board and ask not to move a family if they are of the opinion that this will be particularly damaging for the family members. However, in general they do not have a say when such decisions are made.

Frequent relocations impact negatively on the psychosocial wellbeing of the children. This is strongly underlined by experts and practitioners interviewed in this study. Relocations mean broken relationships with peers and important adults in their surroundings. Interviews with social workers in both Denmark and Sweden emphasis the negative effects these relocations have on children who already struggle to cope with their past and their current situation. The children are not only affected by their own relocations but also the relocations of their friends (interview with pre-school teacher), either as the move from centre to centre, to a municipality when asylum application is accepted or back to their home country if asylum is refused. These multiple broken relationships that asylum-seeking children experience may cause children to give up trying to bond and build relationships with others (interview with psychologist and social worker). Also, research underlines the negative effect several relocations (as well as long residence time in the asylum system) have on children's mental health (Goosen et al. 2014; Nielsen et al. 2009).

4.4.3 Unaccompanied asylum-seeking minors (UAM)

Denmark

In Denmark, UAMs are normally placed in asylum centres, although much smaller centres than what is the case for children in families. Foster home placements are extremely rare while the children are still waiting for their cases to be heard, whereas there are many who are placed in foster homes if and when they have received a leave of stay or asylum.[15] At Vipperød they normally have around 60 residents while at the time of the fieldwork

[15] Email correspondence 23rd November.

(September 2014) as many as 115 UAMs were accommodated at the centre (interview with social worker). Normally, rooms are shared by two or three people. However, with the current situation some had to live in trailers in the parking lot. Kitchens and living rooms are common areas shared by all residents. How meals are organized varies from centre to centre, sometimes depending on whether it is a transit centre or an accommodation centre where the UAM live while their case is being processed. At Vipperød the youth had their meals in a canteen but the canteen was not large enough to cater for the 115 young people currently living there. They therefore had to have their meals in two shifts or some had to eat outside (interview with social worker).

Vipperød centre also disposes a few small apartments outside the centre. This opportunity is offered to minors that have stayed for a long time at the centre, often with a rejected asylum application, and they must be independent enough to take responsibility for themselves. One important purpose is to create as much *normality* as possible during the time before they have to return to their country of origin. The apartments are shared by two youngsters and they receive supervision from the centre staff. Staff at Vipperød voiced that this housing arrangement shows good results and improves the psychosocial wellbeing of the youth living there. The benefits are linked to the increased normality following moving out of the centre, including getting away from an atmosphere of tension and conflict that often characterizes centre life. "If it were up to me, all the unaccompanied minors would live in such apartments" (interview with social worker).

Sweden

In Sweden, unaccompanied asylum-seeking minors may either live at what is called a HVB-home (*hem för vård och boende*), in foster homes (*familjehem*) or with relatives. UAM living at HVB-homes in Sweden have their own room, and at Erikslust they also have private bathrooms. HVB-homes are relatively small accommodation facilities where about 10-15 young people share a resident. The youth at Erikslust (Sweden) were personally responsible for grocery shopping and making their own food (interview with UAM). According to staff, this is a central aspect of preparing integration and independent living. However, stealing is a problem, and therefore they had to have separate cupboards with locks and carry with them a bunch of keys at all times. This system created some stress and dissatisfaction (interview with UAM). It also reduced the sense of homeliness.

For those children and youths who wish and are accepted to stay in foster homes this is an alternative until they reach 21 years. In most cases UAM stay in foster care with relatives (släktinghem) (Stretmo & Melander 2013). Conversations with representatives of Skellefteå reception conducted by Stretmo & Melander highlighted that by far the best form of accommodation was HVB-homes, not foster homes. UAMs do not come to Sweden in order to establish new family relations but they come to seek asylum. In Skellefteå, only those children that absolutely cannot handle living in a HVB-home are offered foster homes (Ibid.). At the same time, interviews at Erikslust, both with staff and foster parents, show that some UAMs both prefer and will greatly benefit from living in a family unit such as a foster home. Support and care by the same adults every day creates a sense of safety and predictability that is not possible to obtain in a UAM-home (interview with foster parents). As one foster mother

expressed: “The advantages of a foster home is that the child may related to only a few permanent individuals. At a HVB-home there will always be changes in personnel. Suddenly one is sick and there’ll be a substitute. In a family, you must be present even if you are sick! People are building more long-term relationships in a family.” Other advantages of foster care mentioned in the interviews are the fact that a family can give a more normal structure in everyday life and that the child or the youth is more rapidly integrated into the new society, through learning the new language faster but also acquiring important knowledge about what family life in the host country looks like. UAMs in foster care will also atomically be included in the social network of the family.

Luxembourg

In Luxembourg, an accommodation of UAM with foster homes has not been reported. UAMs under the age of 16 are placed in a state-run children’s home, but not many in this group arrive in Luxembourg. All UAMs from the age of 16 are first accommodated in the first reception centre Don Bosco. After the initial procedures of age detection etc., the youngsters under 16½ are placed in the Red Cross run centre in Eich (see above), the minors above 16½ are accommodated in a reception centre run by Caritas. None of these reception centres for refugees have a permanent presence of personnel. There is staff taking special care of the minors, but they still have to organize their everyday-lives very autonomously. The ombudsman presented some reflections about this praxis: *“You would never accommodate Luxembourgian minors in such a home, there is nobody by night. It's different from a youth home”.* Minors, who are probably not able to cope with this situation in a responsible manner, are not placed in other accommodation centres, but remain for a longer time in the first reception centre. Another institution for this group is currently planned, but not yet realized.

4.4.4 Good practices regarding accommodation

Through this project we have identified two good practices regarding special residences for specific groups, rejected asylum seekers in Denmark and UAM in Sweden, which seem to create good structures around the children and might have an impact on their psychosocial well-being.

Special residences for rejected asylum seekers (Denmark)

The project of Special residences for rejected asylum seekers started in January 2007 and was offered to some families from Irak, Iran, Somalia and Kosovo that had resided in Denmark three years after the final rejection of their asylum application. The purpose of these Special residences is to normalize the families’ everyday life and strengthen the family before returning home to their country of origin. The Danish Red Cross conducted an assessment in 2009 (Seidenfaden 2009) which aimed to shed light on aspects of relocation which parents’ perceived to have positively impacted on children's psychosocial well-being.

According to the assessment, the vast majority of adults reported that their lives had improved after the relocation to the special residences. This was primarily due to the fact that their children were thriving more, and that they had gained a greater degree of control of their daily life than what was the case while living in an asylum centre. Parents stress greater tranquillity

and stability in the children's everyday life, as well as their enhanced capability to protect their children from violent experiences and incidents that often are part of centre life. Importantly, parents report an improvement in their own mental health after the relocation, which will also impact positively on the children's psychosocial wellbeing. The relocation and maybe particularly the attachment of the children to local institutions like school and kindergarten, increases the families' access to and opportunities for integration and participation in local community activities. However, according to Red Cross there is still a long way to go before this integration potential is reached.

Reception and accommodation of UAM in Skellefteå municipality (Sweden)

Sweden welcomes more unaccompanied asylum-seeking children than any other European country. The number of minor asylum seekers has been high for several years, which has increased their experience and competence in working with this group of youngsters. The municipality which has succeeded the most and which has become a model and inspiration for other Swedish municipalities is Skellefteå. The municipality has received unaccompanied minors with residence permit since 1987, but it wasn't until 2003 that they opened a group home called HVB-home for asylum-seeking minors (Åhdén 2008). This accommodation structure facilitated a special focus on increasing life skills and better coping strategies for this group of children.

The Swedish Save the Children participated in the development of this group home (*Origo*), and also did a couple of follow up studies. Skellefteå's success is closely linked to its health promoting approach to the reception of UAMs. The foundation is that all children should feel welcome and "(…) get a sense of coherence" (Brendler-Lindqvist 2005). The work with the UAM is based on Antonosky's salutogenic approach (1991) which focuses on resources rather than problems. These resources may be found in the child itself but also in the surroundings. Without being blind to the need for professional psychiatric help, their starting point is that each child is a competent, knowledgeable, and responsible person (Åhdén 2008: 511). The aim is to activate human characteristics that may act as a buffer against psychological and social problems. To contribute to increased life skills and better coping strategies is a key objective for this type of prevention efforts (Seligman 2002). The emphasis is, moreover, on building up a functioning social network around each child. Skellefteå has, to a large extent, succeeded in establishing a close cooperation with legal guardians, schools and community activities associations/organisations (interview with Brendler-Lindqvist). Another important element is that the minors are settled in Skellefteå's group homes as soon as possible after arrival to Sweden. In other words, the municipality takes full responsibility for the children throughout the asylum-seeking period until permanent residency is obtained or rejected (Wilmelius et al. 2012). The municipality desires, moreover, that the youngsters choose to stay in Skellefteå after having obtained a residence permit, thus the effort of taking care of and integrating the UAM has a long-term perspective (interview with Brendler-Lindqvist).

The success of copying the model of Skellefteå depends on several factors, not the least people's perceptions of and attitudes towards asylum-seeking children, the willingness of a

whole society to care for and integrate them, and maybe also the long-term perspective so clearly visible in Skellefteå. What is also of interest is that the reception of UAM in Skellefteå mainly focuses on social integration and less on psychological rehabilitation (interview with Brendler-Lindqvist).

4.5 Education

The importance of the activity and routine of going to school, alongside the actual learning, is highlighted by the interviewees (parents, youths, practitioners and experts) as beneficial to the psychosocial wellbeing of asylum-seeking children and youth. In general, education of asylum seeking children falls under national education laws, meaning that they have the same right to education - same content and same number of hours - as *native* children. They also have the same right as other children to special assistance and individually adapted teaching. However, language barriers as well as the children's different educational backgrounds make it challenging to fulfil these rights from day one.

4.5.1 Kindergarten and pre-school

Denmark

All children from 3-6 years old may attend the kindergarten at Avnstrup in Denmark. Currently, the kindergarten is open five hours a day (interview with preschool teacher). The approach of the Red Cross kindergarten is based on the STROF model, which will be described under the section *good practices* below, and Joyful Play. Methods developed with the aim to both support and to heal traumatized refugee children are used. Red Cross use psycho-educative methods, such as methods to teach young children to distinguish between different emotions and how emotions are expressed (interview with project leader friRum). The pre-school teachers at the kindergarten are committed to contribute to a sense of coherence in the young children's lives. For instance, when a new child arrives in the kindergarten they always sing Brother John (*Mester Jacob*), as this song is also sung in the first reception centre at Sandholm (interview with preschool teacher). The song continues to be a recognizable element in the daily circle time. Also, each child gets a personal folder where drawings, photographs etc. are kept, and which they will bring with them when they leave Avnstrup. This may contribute to a sense of coherence and link different phases of their lives together. As long as the children live at Avnstrup the folders are kept in the kindergarten in a shelf that is easily reachable for the children. According to one preschool teacher in the kindergarten, the children show great interest in their folder, and can spend quite some time looking through it.

As the children do not share a common language in the kindergarten it is viewed as very important to have clear structures and predictable routines to ensure more clarity and a sense of security. Staff at the kindergarten is of the opinion that children with war-related traumas need a special focus, and they have both the competence and the methods in place to support these children. Staff also highly value and seem to have a good collaboration and dialogue with parents (interview with preschool teacher). Staff at Avnstrup encourage parents to spend time with their children in the kindergarten in the beginning to help the children feel safe.

This practice is stressed as important by Guhn Godani, one of the experts interviewed in Sweden, who has worked closely with traumatized parents and children:

> In a war or flight situation what parents do is to keep their children close, to protect them, and to ensure that they are not separated from each other. One should therefore not force them to an 'early separation' when arriving in the exile country (Interview with Guhn Godani, authors' translation).

An early separation may be very scary both for the child and the parents. Entry into kindergarten should happen when both parents and child are comfortable with the separation. Asylum-seeking parents should, according to Godani, be allowed a longer transition or introduction period where they could stay together with their children in the kindergarten.

> I believe that many children are so traumatized that they first will need a kindergarten where they can land and find safety before they enter the public kindergartens. The child may easily be misinterpreted. There is a risk that the child receives a wrong *diagnosis*. My personal experience suggests that the majority of asylum-seeking children first need some structure in their lives, then they need time and space to allow the reactions to come, and only after that process a positive development re-start may begin. Many children will be at risk of falling through if they immediately enter into public kindergartens (interview with Godani, authors' translation).

The Avnstrup kindergarten is located in a reception centre and normally residents are not supposed to stay for long. Nonetheless, several end up staying for many months and sometimes even years, also families with children (interview with social curator). If a child has stayed for a long time and is viewed to no longer benefit from the pedagogical approach at the kindergarten at the centre, the staff will, on behalf of the parents and the child, apply for a place at a public kindergarten (interview with preschool teacher).

<u>Sweden</u>

Young children in asylum-seeking families in Sweden have the same right as other children to attend kindergarten (*förskolan*). In some municipalities there are kindergartens that are especially adapted towards the situation of newly arrived asylum seekers and refugees. Children are entitled to free kindergarten 15 hours per week (three hours per day) from the child is three years old. After the child is registered in the municipal queuing system it should take maximum four months before the child gets a place in a kindergarten (Rädda Barnen 2012). Let's take Malmö as an example. In this municipality there is no coordination entity for kindergartens, with the consequence that the newly arrive asylum-seeking parents must themselves notify a municipal or private kindergarten (Ander 2012). However, asylum-seeking families who change residence, which is not uncommon for asylum seekers in private accommodation, may create situations where the family never gets the acceptance letter or are placed at the bottom of the queue if they move to another neighbourhood (Ibid.: 119). In Sweden there are also open kindergartens, where parents can bring their children to play for some hours, which are free for everyone, including asylum seekers. Open kindergartens have been under a lot of pressure due to a rising number of children and are therefore at times forced to refuse more children.

Luxembourg

In Luxembourg compulsory school age is 4 while early childhood classes are available from the age of 3. Early childhood education, which is designed to improve children's social skills and to teach them Lëtzebuergesch as the language of communication for all children, irrespective of their nationality, is optional for children from 3-4 years of age. Preschool education, on the other hand, is compulsory and starts from children's 4th birthday. School hours are usually about 4 hours Monday to Friday as well as two hours in the afternoon on Monday, Wednesday and Friday. Asylum-seeking children have the same right to attend early childhood education and pre-school as other children in Luxembourg.

4.5.2 Schooling

Denmark

The Danish Aliens Act (2009, § 42g) states that asylum-seeking children "(…) shall participate in separately arranged tuition or in tuition measuring up to the general requirements under the separately arranged tuition." The separate schooling, either run by the Danish Red Cross or by municipalities, follows the *reception class program*. Rydin et al. argue that "Municipal schools with reception classes have guidelines about goals, contents and expected results, but there are no references to the special needs of children from asylum seeking or refugee families" (Rydin et al. 2012a: 11). The purpose of the Red Cross schools is to prepare children at asylum centres for public school. The time spent in the Red Cross school may also allow children the time to find emotional stability in their new situation before they start schooling in the public system (Rydin et al. 2012a; interviews with social worker and pre-school teacher). When children are enrolled in public schools depends on the child's proficiency in Danish, but also on how long the child must live at the asylum centre (interview with social worker). Children should, however, attend the asylum centre school for only one year before they are transferred to a normal public school, unless there is documentation that this will not be to the advantage of the child (Danske Røde Kors 2011).

The main focus, at least at the Red Cross school, seems to be on teaching the Danish language (Egelund & Maribo 2009). In the Red Cross schools, the children are grouped in small classes and these schools are therefore characterized by few pupils per teacher (interview with social worker). Teaching is divided into three levels: Level 1 which is for 0 to 3rd graders, Level 2 for 4 to 6th graders, and Level 3 which is for 7 to 10th graders (Allerød Kommune 2012). "Skolen på Bakken" provides schooling for the centres at Avnstrup, Kongelunden, Sandholm, Kvindecentret, Vipperød and Jægerspris (ibid.). Long travel distances (up to two hours a day) has been noted as problematic (Jessen & Montgomery 2010; Rydin et al. 2012a).

Undocumented children still do not have guaranteed rights to education in Denmark. Rejected asylum-seeking children may, on the hand, continue schooling until they are returned to their home country. But in Denmark these children do not have a legal right to choose public schools and might therefore only be offered to continue studying in a Red Cross school. A problematic aspect here is that the *reception class program* is not validated as official education in Denmark, nor anywhere else, and consequently Jessen and Montgomery (2010)

describe this education as *lost years*. Moreover, asylum seeking youth in Denmark have access to the educational system only until they are 17 not 18 (Jessen & Montgomery 2010).

Sweden

Compulsory school age in Sweden is normally from 7 to 16 years, however, for asylum-seeking children schooling is a right but not an obligation (Bourgonje 2010). From 1 July 2013, also undocumented immigrant children have the right to education in Sweden (Utbildningsutskottets betänkande 2013). Some municipalities place asylum-seeking children straight into *ordinary classes* (with some extra help), but most children attend what is called *introduction, transitional or preparatory classes* (Rydin et al. 2012b). Under-18 year-olds have the right to attend the upper secondary school (Ibid.). The Swedish School Inspectorate (*Skolinspektionen*) reveals that not even half of the municipalities offer asylum-seeking children teaching in all the subjects that other pupils in the public schools receive. Rather they offer some kind of adapted curriculum (Skolinspektionen 2013). A recent assessment by this Inspectorate shows that a high rate of asylum-seeking children are not in school, the estimates being approximately 78 % of children of primary school age, and about 59 % of those of high school age (Ibid.). The fact that education is not compulsory for asylum-seeking children is partly to blame, but the freedom to choose private accommodation is also likely to contribute to children remaining unknown to the municipalities and their school systems.

Social integration into the new society is underlined by all youths and parents interviewed in Denmark and Sweden as important for the children's everyday psychosocial wellbeing. Schools are seen as an essential arena with the potential of facilitating making friends with *native* peers. However, none of the youths interviewed were yet enrolled in regular classes but studied either at a Red Cross school (Denmark) or in inception classes segregated from the rest of the school (Sweden). This makes it more difficult to learn the language, as revealed by one of the interviewees currently in a preparatory class in a public school:

> At my school there are mostly Arabs so not very easy to get integrated. But at least we learn Swedish. There are some Swedes there also but since most are Arabs people also mostly speak Arabic at school. It would definitely have been better to go to school with more Swedes (interview with UAM).

None of the two youths interviewed in Sweden had any lessons in a regular Swedish class; all their teaching took place in the segregated inception class. The School Inspectorate confirms that this is the case for some asylum-seeking children; some actually studies at schools where there are only other newly arrived immigrant children (Skolinspektionen 2013: 14).

Asylum-seeking youth in Sweden who have begun to study in high school before they turn 18 are entitled to complete high school/upper secondary.

Luxembourg

School attendance is obligatory for any child or adolescent from the age of four to sixteen, and every child of this age living in Luxembourg has the right to attend school, independently of the nationality or the legal status of the parents (MEMORIAL 2009:Loi du 6 fevrier). This means, that even children whose parents reside undocumented in Luxembourg are regularly accepted as pupils in public schools (Interviews with the Ombudsman for children's rights).

Before they are enrolled in public schools asylum-seeking children attend language classes at the first reception centre. Children of asylum seekers or UAM are integrated either within *mainstream classes* with special support, or in *reception classes* for newcomers to the country. Asylum-seeking children under the age of 12 are enrolled at the school service in the commune, where they reside, after leaving the first reception centre. As in Denmark, reception classes have been installed to provide the acquisition of the languages for newly arrived migrant and refugee children. When attending regular schools, immigrant pupils are given support to learn the required languages in additional *reception courses*. These language courses take place within the school.

According to the interviewees (practitioners and expert), the young refugees' insertion to schools works quite well. The major challenge asylum-seeking children have to face entering the Luxembourgian education system is the trilingualism of the country. They have to acquire Luxembourgish (*Lëtzebuergesch*), a German dialect, which is the everyday language spoken in Luxembourg. Young children might learn it in the compulsory pre-schools. German is the main language of instruction in elementary school and lower secondary education and is introduced in the first year of primary schools. French, the legislative language in Luxembourg, is introduced in the second year of primary schools and most subjects in higher secondary education are taught in French (Ingleby 2012; European Commission 2014). This means, arriving at an older age to Luxembourg, pupils have to learn three languages at once, and if they want to continue their academic career, in many cases it is also necessary to learn English. Supplementary courses and special classes are available to help with French and German.

Children and youth between 12 and 17 have to address the foreign pupils' school service of the Ministry of Education (Cellule d'accueil scolaire pour élèves nouveau arrivants, CASNA). A test on the children`s scholar knowledge constitutes the basis for recommendation regarding the level of enrolment in a Luxembourgian school. CASNA offers different kinds of support to newly arrived pupils, their parents and teachers. For instance, diversity training is offered to teachers. Maybe most importantly, they employ intercultural mediators to facilitate the integration of immigrant pupils within the education system. The intercultural mediators provide interpreting services in different languages for information meetings on the school system, meetings between teachers and parents, or visits to school doctors or psychologists.

The Luxembourgian school system has for many years been criticized for its selective and socially unjust character, failing children from socio-economically disadvantaged backgrounds, in particular migrant children:

> Despite spending more on its schools than any other country in Europe, Luxembourg ranked lowest for the quality of its public education, according to the reports from OECD's Program for International Student Assessment (PISA) in 2001 and 2003. Both reports emphasized the selective character of Luxembourgian education and its socially unjust character, which exacerbates social inequalities instead of reducing them. The result is an excessive number of failures. Dropout is high (…). Half of all students will leave secondary school without a qualification (Ingleby 2012: 7).

After a succession of highly critical reports on the school system, major reforms of the school system have been implemented. Organisational measures are taken for integrating students belonging to risk groups and marginalised groups (European Commission 2014). The frequentation of the same school by Luxembourgian as well as immigrant children is seen as an indispensable element to ensure social cohesion (ORK 2013: 44).

Although a wide range of measures have been implemented during the last years and the approach is very positive, the Ombudsman for children's rights states that the transformation is yet neither easy nor ideal. The conditions in some accommodation centres (narrow and dark rooms, shared by the whole family) are not favourable for children having to do their homework. The children living in big reception centres are integrated into the school system only with difficulties (ORK 2013). The practitioners state that school plays an important role for the integration into society for refugee children. For them, attending a regular school is part of regaining *normality* after traumatic events in a war.

4.5.3 Good practices regarding Education

In this section we will present the STROF model used in the Danish Red Cross asylum centres, schools and kindergartens, followed by one example of how to strengthen teachers' and preschool teachers' skills and capacities related to war-affected asylum-seeking children, and finally an example of a good practice with regards to a rapid integration in regular classes.

The STROF model (Denmark)[16]

The STROF model was originally called the STOP model and was developed by the Swedish pediatrician Gustafsson for working with children with refugee backgrounds (Gustafsson et al., 1989). Some years later the Danish Edith Montgomery (2000) further developed the model by incorporating an additional element, namely rituals. The five main areas of priority are; S for structure, T for talking and time, R for rituals, O for organized play and F for parental support (foreldrestøtte) (Dansk Røde Kors Asylafdeling 2011:11-15).

The purpose of using the STROF model is to improve the psychosocial wellbeing of asylum seeking children by creating structure, a sense of safety and predictability in the lives of these children. This need for structure and a sense of safety is also confirmed in interview with a psychologist and a psychiatrist. Structure and daily routines are beneficial for a child who experiences internal chaos; it may help the child to avoid becoming "(…) overwhelmed by their own emotions" (Montgomery & Linnet 2012: 65). The T in STROF, in addition to talk and time, may also be linked to trust. This trust is, however, slowly established through taking the time to talk with and listen to children having had troubled and traumatic experiences. Through talking about his/her situation and past experiences, consequently developing the ability to express feelings verbally, the child may become more capable to structure past events and reduce the internal chaos (Montgomery & Linnet 2012). The reason why rituals were included in the model is that rituals and ceremonies may contribute to and facilitate a

[16] The STROF (or STOP) model has been identified as good practices by Danish Red Cross staff and in literature on asylum seeking children, for instance, Fladstad (1994), Neumayer et al. (2006) and Montgomery & Linnet (2012).

healing process.[17] As noted by Montgomery & Linnet (2012: 66), "play can be healing and a part of the child's processing of its traumatic experiences." At the same time, play may also become pathological (Ibid.). It is therefore important that the play is organized in such a way that it may have a healing effect on the child. In other words, the child needs the help and support of an adult to organise the play to facilitate the processing of the grief and traumatic experiences asylum seeking children bring with them. Last but not least, the STROF model involves parental support. Not only the children but also often their parents have experienced and witnessed horrible things in their home country and during the flight. Parents may therefore need rehabilitation themselves, but also more knowledge and guidance with regards to their children's trauma reactions.

STROF is also one of the main pillars guiding the general care and support at all the Red Cross' children and youth centres for unaccompanied minors (Dansk Røde Kors Asylafdeling 2011), and is particularly used in their schools and kindergartens. Capacity building in STROF is provided to all Danish Red Cross staff in the Asylum Unit (interview with social worker). Interviews stressed the importance of a common approach by all staff members. Staff "doing things differently" could be confusing and reduce the desired predictability and the sense of control of the situation which structured daily routines could bring about in the children.

> I believe that also the majority of Danish children would also benefit from the STROF model, but I know from experience that for the asylum seeking children there would have been chaos if we did not have such an approach. It provides a sense of safety and a framework in which to figure things out and get a normal development again. They have experienced violence and perhaps many months without any kind of structure. It gives them a feeling of powerlessness and lack of control. In war everything is out of control. Also during the flight everything is out of control (interview with preschool teacher).

Joyful Play (Denmark)

The organized play in the Red Cross kindergarten uses a method called *Joyful Play* developed by Steve Gross. The purpose of the method is to train adults on how to help children to enter into powerful, healing play. The Joyful Play training manual (Gross 2007) describes the philosophy behind the method and gives concrete examples of joyful, inclusive, empowering and healing games. The method targets "at-risk" children; children who have suffered abuse, been witnesses to violence, experienced trauma, or who have lived in environments of poverty and uncertainty. These children tend to require additional help to play successfully: social and emotional obstacles experienced among these children "often result in children withdrawing from play or engaging in play in an overly aggressive and reckless manner" (Ibid.: 3).

War-affected asylum-seeking children with traumatic experiences are likely to benefit from this approach (interview with psychologist and psychiatrist). The method has a clear vision about how Joyful Play will help traumatized children. "Physical play is one of the most effective ways for children to process and "work through" traumatic experience. Since

[17] Traditional cleansing and healing rituals have been shown as facilitating social acceptance of former child soldiers in some communities, for instance, in Sierra Leone (Wessells 2006) and in Mozambique (Boothby et al. 2006).

physical helplessness and failed action are at the core of psychological trauma, it is essential that children be given ample opportunities to engage in coordinated, victorious action that allows them to feel safe and powerful. In addition, since survivors of trauma often feel forsaken and alone, it is essential that children be given ample opportunities to engage in intimate, collaborative play that allows them to build trusting and caring friendships" (Ibid.: 14).

Not only staff in the Red Cross kindergarten but also the rest of the staff at the Asylum Unit has undergone training in the Joyful Play method (interview with preschool teacher). Joyful play methods were also used after the Katarina storm along Mississippi`s Gulf Coast in the U.S (see *Life is good. Playmakers*). A study was conducted while implementing this project that involved ten pre-school teachers from classrooms that participated in the project and ten others that served as a 'control group'. The study measured the impact on the fifteen-week curriculum on the children`s social-emotional well-being and found that "Children participating in Powerplay became significantly less depressive, anxious, angry, isolated, aggressive, and oppositional. And they became significantly more joyful, pro-social, and independent" (Ibid.: 8).

Rapid integration in regular classes (Sweden)[18]

As mentioned in an earlier chapter, several studies highlight a rapid integration of asylum seeking children as good practices in the education of newly arrived migrant children (e.g., The Swedish Association of Local Authorities and Regions 2010; Public Policy and Management Institute 2013). The main argument being that asylum-seeking or other migrant children in highly segregated schools are likely to have less incentive and fewer opportunities to rapidly learn the native language of the exile country. Psychological arguments for a rapid integration into regular classes are also put forward in several interviews, not least the psychological advantage of spending time with non-traumatized children in a 'normal' setting outside of the centre.

The School Inspectorate's report from 2009 provides us with an example of two schools in Bollnäs municipality with a good practice related to schooling of asylum seeking children. From the very beginning every newly arrived pupil belongs to an 'ordinary' class. Although they have some separate lessons from their 'native' classmates (introduction class), they will have training aimed at for example psychosocial wellbeing, drawing and cooking lessons together with their 'ordinary' class. "As soon as the pupils have achieved basic knowledge of a subject, they move to the ordinary class. Often they are integrated into ordinary lessons after only two or three weeks" (Rydin et al. 2012b: 203). The schools also have a policy on encouraging parents to participate in school during the first two weeks after their children start schooling in Sweden. The main purpose is to increase asylum seeking children's feeling of security, but a secondary purpose is to help parents get an understanding and knowledge of the Swedish school system (Skolinspektionen 2009). A rapid integration of asylum seeking children does not happen without proper planning, of which these two schools are good examples. They have clear guidelines and a substantial plan for the integration of newcomers.

[18] Highlighted as good practices by the Swedish School Inspectorate (Skolinspektionen, 2009) and Rydin et al. (2012b).

They have tracking mechanisms in place for assessing the children's writing, reading, mother tongue skills etc., and the teaching is "adjusted to the pupils' prior education and knowledge, age and needs" (Rydin et al. 2012b: 203).

Intercultural mediators (Luxembourg)

Integration into regular classes and public schools poses challenges both to the newly arrived children and to teachers and teaching methods at schools. The measure of intercultural mediators put in place in Luxembourg is a fruitful approach to facilitate this integration. Not least through provision of interpreting services in different languages for information meetings on the school system, meetings between teachers and parents, or visits to school doctors or psychologists.

4.6 Recreational activities

There is a general agreement that recreational activities and *to stay busy* are important for asylum seeking children and youth (e.g. Kalksma-van Lith et al. 2007; Mels et al. 2008; Montgomery & Linnet 2012). It is important not only for their physical health but also for their psychological health and well-being. Several interviewees in all case countries stress the extra advantages linked to participating in a recreational activity *outside* the centre. To be a part of a football club or a choir in the community opens up the possibility to make friends who live outside the centre. This increases integration and the child's chance of becoming more familiar with the new society. One should, moreover, not ignore the positive effect it may have for an asylum seeking child to spend time with *native* children in more normal life situations which might contribute to *a sense of normality*.

Denmark

Children at Avnstrup are provided after-school activities equivalent to after-school activities provided to other children in Denmark. There is one children's club for 6 to 12 year-olds (Mini-club) and a youth club for those between 13 and 17 years (Maxi-club). In addition, children may participate in recreational activities outside the centre (interview with social worker). The Mini-club is open 980 hours per year while the Maxi-club is open 1,176 hours per year. It is ensured that the clubs may also be open during summer, autumn and winter holidays. Asylum-seeking children between 6 and 17 years and their parents are informed about the opportunities to participate in local recreational activities when they arrive at the centre. There is a *Culture and Recreation Coordinator* who is in charge of establishing cooperation with clubs and associations and explores new opportunities for collaboration. All costs related to membership, transport, outfits etc. are to be covered by the Red Cross budget (interview with social worker). According to the social worker, activities like martial arts are particularly useful for children with a lot of aggression; it is a good manner to ventilate negative emotions, but they also learn strict discipline.

Recreational activities are a priority at Vipperød centre (interview with social worker). Underlying objectives are to get the young people's minds off painful memories, longing for and concerns about family and friends back home, and worries about the future. It is particularly "(…) important that the boys get out some steam" during the day as this has a

clear positive effect on the atmosphere and conflict level in the evenings (interview with social worker). At the same time, staff at Vipperød also see it important to try to get 'physical boys' to do more tranquil activities, like painting and bead work. The girls are in minority, around 13-14 % of the residents. They may have different needs as well as interests than the boys and therefore some activities are organized exclusively for the girls (interview with social worker). Most activities take place at the centre, sometimes with volunteers participating. Danish Refugee Council has, for instance, a program called *Leisure for Refugees* which initiates recreational activities at Vipperød centre, as well as excursions and events outside the centre. But on an everyday basis activities are initiated by staff members or by the youths themselves.

There are inadequate financial resources set aside for recreational activities for asylum-seeking children in Denmark (interview with social worker). Regular participation in sports associations or other recreational activities outside the centre is therefore limited. According to one interviewee this can only happen if the sport association is willing to cover the costs. Consequently, these types of associations are most interested in youth they may invest in over some time, that being youth with temporary residence permits or rejected asylum applications from countries with which Denmark has no return agreement (interview with social worker). Many of those living in the apartments outside the centre are in this category and are therefore more often affiliated with a fitness centre, a football club or a wrestling club.

Due to limited funding the Danish Red Cross' Asylum Unit and asylum centres must seek to obtain private funding to increase asylum-seeking children's participation in recreational activities. One centre, in collaboration with a regional Gymnastics and Sports association (DGI), have recently applied for the funding of a project entitled *Health and associational life for all*[19] (Røde Kors Danmark 2014). In 2012 and in 2013 Danish Red Cross, with funding from TrygFonden, organized *Asylum cup* where about 400 asylum seekers participate each year (Ibid.).

Sweden

In Sweden, Attendo's policy related to UAMs' participation in recreational activities is to encourage and facilitate participation and support it with 300 SEK per month per youth. HVB-homes operated by municipalities would normally also cover some expenses related to recreational activities, but the amount tends to be lower than 300 SEK (interview with social worker) and there are also variations across municipalities. At Erikslust they have developed a structured approach to guide staff members' work regarding recreational activities. Their approach is called *The Motivation System*, and is a tool to promote the youths' motivation to participate in recreational activities, develop their identity and facilitate their integration into Swedish society. This system will be further outlined in the section on good practices.

Luxembourg

Within the first reception centre in Luxembourg, recreational activities are offered especially to the children. Twice a week (in the school-free afternoons), an educator offers sports or handcrafting activities: *"*We do excursions, we play outside. Everything children in a normal

[19] Sundhed og foreningsliv for alle.

contact would play or do*"* (interview with staff). Once a week, volunteers come to the centre to read, paint or play together with the children. There are no efforts undertaken to support the integration into recreational activities outside the first reception centre, because the children's stay there is limited to a few days up to weeks. As soon as the families or the unaccompanied minors leave the first reception centre and move to the centre where they will live during the asylum procedure, they receive support to build a *normal every-day life*. They are asked what kind of leisure activities or sports they would like to do, and they receive support to find a sports club etc. They assist the same sports clubs as the other inhabitants in the village, where they are transferred to (interview with psychologist). The ombudsman states, that the participation in a sports club can be limited at some point: if the youngsters want to participate in a more professional team, they cannot achieve a player's license if they don't have a legal stay in Luxembourg. Once a year, holiday camps are organized, where refugee children can go on vacation together with Luxembourgian children (interview with educator).

4.6.1 Good practices regarding Recreational activities

The Motivation System (Sweden)

Through this project we identified one good practice when it comes to recreational activities. Attendo's approach *The Motivation System* is a tool to promote the youth's motivation to participate in recreational activities, develop their identity and integrate into Swedish society. The purpose is to provide an "(…) opportunity for meaningful leisure, which in turn increases their well-being and sense of coherence."[20] The young person signs a contract with his or her contact person at the residence, and the contract shall include timeframes for reaching identified intermediate and main objectives. If the young person does not have any special interests his or her contact person at the residence should help him or her to try different activities before a contract is signed. Examples of recreational activities can be to participate in a team sport, work-out in a gym, learn to play a musical instrument, join a study group to learn something new. The contact person shall have continuous motivational conversations to follow up on what has been agreed upon in the contract. The Motivation System covers the costs associated with the activity (for example training fee at the gym), but it cannot exceed SEK 300 per month. Costs on top of that must be covered by the youths themselves.

4.7 Health care and Rehabilitation

Various studies reported in literature show that children who have experienced war at close range have a high risk of developing psychological problems, sometimes even chronic ones, such as depression, anxiety and traumatic stress reactions. Available research shows that unaccompanied children are particularly vulnerable to mental health problems (Eide 2012). But also asylum-seeking children in families are vulnerable to psychological distress. In fact, they may be exposed in a dual sense as they may suffer due to personal traumatic experiences but also due to the psychological problems of their parents. Recently, we have also seen an increasing awareness and attention to how children, also babies, are affected by traumas of their parents (e.g., van Ee 2013; Brendler-Lindqvist et al. 2014; Daud 2008).

[20] From the Project Guidelines.

In all three case countries, asylum-seeking children under the age of 18 have the same right to health care as other children in the country. This includes treatment by child psychologists or child psychiatrists. Adult asylum seekers, on the other hand, do not always have the same rights as national citizens.

4.7.1 Physical health care

Denmark

Asylum-seeking children in Denmark are offered a physical health examination at a Red Cross Clinic. The general purpose of these health examinations is to find out if the child has any health problems and if any care is needed. The health clinics at Danish Red Cross are normally staffed with a nurse, a public health nurse/school nurse and a doctor. The residents at the asylum centres are typically treated for health problems such as infections, sore throat, abdominal pain and sleeping difficulties. According to the latest contract between the Danish Immigration Service and the Danish Red Cross, Red Cross may also pay for specific health services within the areas of psychological and psychiatric treatment, medical specialists, dental care, physiotherapy, occupational therapy and podiatry (Utländingsstyrelsen 2014: 6). The funding for such specific health services has a maximum of 3.000.000 Danish kroner (about 480 000 USD) per year for the totality of asylum-seekers (both children and adults).

Sweden

Also in Sweden asylum seekers are offered a voluntary health examination upon arrival. The public Health Care Centres are responsible for carrying out health examinations of asylum seekers, normally done by a nurse. In Malmö there is a specialised Refugee Health Centre (in Skåne County) which serves asylum seekers in the areas of Malmö and Trelleborg. The centre is in charge of the health examination as well as medical advice and treatment of asylum seekers. Based on the results, many patients are referred to various other health care institutions/services. This is for instance the case for approximately 85 % of UAMs examined by the Refugee Health in Malmö (Socialstyrelsen 2013b: 21).

The likeliness that every asylum seeker actually attends a health examination is higher in Denmark than in Sweden. This is linked to the combination of the voluntary nature of the examination (also the case in Denmark) and the fact that 60 % of asylum seekers in Sweden live in private accommodation (SOU 2009: 66). Hence, no one is making sure that the asylum seeker shows for the health screening appointment (interview with nurse). We are not aware of the size of this problem, but it is not unlikely that this also affects some children.

Luxembourg

Asylum seekers are granted free access to medical treatment in Luxembourg. Due to Article 1 of the regulation on social aid for asylum seekers of 2012 the state provides them with basic medical treatment after their arrival and takes over the costs for *the voluntary social*

insurance[21] (Institutions de sécurité sociale 2011: Art.2, MEMORIAL 2012: Règlement grand-ducal du 8 juin 2012). During the first three months of their stay in Luxembourg, they receive vouchers to pay for the doctor. Then the voluntary social insurance covers the medical treatment in the national health system. The practitioners and the expert's statements in the interviews acknowledge that asylum seekers have the same access to medical treatment as any other person living in Luxembourg. Parallel structures are not seen to be necessary or beneficiary.

4.7.2 Psychological and psychiatric health care

Denmark

The Danish Red Cross has a *Psychological Unit*, centralized in Copenhagen, which serves the whole country. This Unit has a specialised *Child Unit* focusing on the needs of asylum seeking children. The psychologists travel to different asylum centres to undertake psychological screenings (interview with psychologist and psychiatrist). In August 2008, the Danish Red Cross and the Danish Immigration Service signed an agreement stating that all newly arrived asylum seeking children should get a psychological screening. The government is financing the screening. However, with rising numbers of asylum seekers it has been difficult to reach the goal of the 2008 contract. The contract in 2013 was changed to screening of 700 children, while the current (2014) contract requires the Red Cross to screen all *vulnerable* children. To evaluate whether a child is vulnerable or not they use what they call *The Child Ruler* (børnelinealen) (interview with psychologist), which categorizes between 5 types of situations: 1) Ordinary children with ordinary problems, 2) Children with temporary risk of social problems (sensitive children), 3) Children with specific needs of chronic or long-term nature, 4) Children with significant need of special support and 5) Children with obvious risk of suffering serious harm. With regards to children in category 4) and 5) there is an obligation by Health and Social Services (Social- og sundhedsforvaltningen) to provide supportive measures. According to interviews, Social Service should already be involved with regards to asylum-seeking children belonging in category 5). The main focus of the Child Psychological Unit at the Danish Red Cross is on screening and supporting children in category 3) and 4). The Child Ruler is a tool which specifies concrete assessment criteria for each category regarding the child, parental skills/capacities and the child's broader network. The screening should normally take place within the first three months after arrival to Denmark. This, however, is not always the case (interview with psychologist and psychiatrist). The Psychological Unit used to employ the Strengths and Difficulties Questionnaire (SDQ) but abandoned this tool as it proved not well adapted to the target group. "Many of those we screen have very little or no schooling, are not familiar with this kind of questions, nor to answer using a scale from 1 to 5" (interview with psychologist). Currently they use a semi-structured interview guide that has been developed by the Psychological Unit at the Red Cross. The screening of children in families is based on a conversation with the parents about the

[21] Normally, inhabitants in Luxembourg are members of the compulsory public health insurance which allows free access for basic healthcare. Those in work as well as employers contribute with 10% of their gross income. Asylum seekers and other who do not have immediate access to the labour market become members of what is called *voluntary social insurance* providing them free access to the national health system.

family, the parents' well-being, and the children's well-being and development. Screening of UAM is done through a conversation with the young people themselves.

The purpose of the psychological screening is "(…) to identify the asylum seeker children who have either developed or are at risk of developing psychological difficulties or who have other special needs upon arrival in Denmark" (Shapiro et al. 2010: 6). Results from psychological screening of children in 2009 shows that about 20 % have been in life-threatening situations, 38 % live in families where at least one parent has been subjected to torture, and 60 % live in families where at least one parent has been subjected to violence (ibid.). The results indicate that 32 % are at high risk of having psychological problems or mental illnesses. About 56 % are deemed to need "(…) coordinated psychosocial attention" and are therefore assigned to multidisciplinary psychosocial teams (Ibid.: 6). Measures and interventions offered to children in need of special care are often family-focused support with a strong element of psycho-education.

Children who need to receive individual counselling and treatment must travel to Copenhagen to attend sessions with psychologists or psychiatrists at the Child Unit (interview with psychologist and psychiatrist). This seems inconvenient, probably creating an extra barrier for both children and their parents, who in many cases will have to accompany them to Copenhagen. The interviewed psychologist expresses that the travel distance may increase the likeliness of children and youths not showing up for their sessions, and holds the view that it is better if "(…) we meet them where they are." Nonetheless, due to Denmark's small size the centralized unit works relatively well. In addition, the social curator or social worker at the centre may organize different interventions/measures like drawing therapy, music therapy, bilingual social educator, and bilingual support person. Some children also participate in friRum groups and Joyful Play activities. About 40-50 out of the 800 residents that stayed at Avnstrup at the time of the fieldwork had some kind of special support (interview with social worker).

Except for *friRum* and *Joyful Play*, where Red Cross has competent facilitators among their own staff, they normally buy services from Solvita[22], a consultancy agency with specialised competence on traumatized children, youths and adults. Solvita includes a variety of professional disciplines - psychologists, music therapists, acupuncturist, social educators and mentors – who work jointly to solve the psychosocial tasks. Their staff is multicultural and therefore also fluent in the mother tongue of children and adults at asylum centres. The social curator at Avnstrup notes that they have particularly good results with a *family-focused support* which combines a bilingual social educator and a music therapist. "The boy who was suicidal, who refused to go to school and would never be away from his mother, he started school again after only two sessions with the social educator and the music therapist. He is not quite in place, but there is a great progress in a very short time. But it is still a long process that must be followed up to avoid relapse" (interview with social worker).

[22]For more information: http://www.solvita.dk/

Parents interviewed at Avnstrup also hold the view that music therapy combined with a social educator is a fruitful method. However, what they value the most is what is called a *support person.* These approaches will be outlined in the section on good practices.

Sweden

Psychological screening of asylum-seeking children is not part of the health services offered in Sweden. However, part of the conversation during the general health examination should be about the child's psychosocial situation or traumatic experiences and how these may affect how he or she feels today (Socialstyrelsen 2013a: 94). According to the Refugee Health Centre in Malmö the children often reveal psychosomatic problems such as concentration difficulties, sleep problems, headaches, tension, poor appetite, dizziness and sadness (Socialstyrelsen 2013b: 21). If an asylum-seeking child in Sweden is in need of psychological or psychiatric interventions the entity in charge is the *Child and Adolescent Psychiatry* (Barn och ungdomspsykiatrin - BUP). When a child is referred to BUP, BUP is obliged to carry out an assessment of the child within 3 months and according to the result of the assessment it will be determined whether or not to initiate immediate measures or interventions. According to an interview, BUP assessment is often done within a month after the child is referred. It should, however, be noted that a recent report by Stretmo and Melander (2013) reveals that some BUP receptions do not accept new registrations of young people who have turned 16 and some do not accept children who are in the asylum process. This means that asylum-seeking children in need of psychological or psychiatric treatment are not necessarily provided the same care in every municipality in Sweden.

Another interviewee, a nurse within the primary health services (Vårdcentral), notes that BUP only treats "severely ill children". Depending on the needs of the child she may encourage him or her to rather contact the *Youth Reception* (Ungdomsmottagningen) or the *School Health Services* (Elevhälsan). Staff at the Youth Receptions includes a midwife, social worker/curator and most often also a medical doctor. Some Youth Receptions also have a psychologist, a nurse and a psychotherapist. The School Health Services are present at all schools from grade one to the end of upper-secondary/high school (gymnasiet). Here the children get help and support from a school nurse, a school doctor, a school curator, a school psychologist, and a special educator (spesialpedagog). When the situation is more critical the nurse responsible for the health examination will send a referral of concern to the Social Service. Upon an assessment of the child's situation and well-being, the Social Service may decide to initiate measures aimed at the individual child or in-home measures aimed at the family. One measure may, for instance, be sessions with a child psychologist (interview with social worker).As long as the child is in the asylum-seeking phase the Migration Board is financially responsible for these measures/interventions.

BUP Farsta, which participated in this study, has a specialised unit for asylum psychiatry which is particularly responsible for therapy and treatment of asylum-seeking children. Similarly in Malmö we find the specialist team for war and torture injured (Team for krigs- och tortyrskadade -TKT). Their competence, both with regards to treatment of traumatized children as well as the consultative role they have to the general BUP system, is well spoken of by interviewees at BUP. However, most municipalities do not have specialised units/teams

with staff being particularly competent on treating asylum seeking children and children victims of war. Variations in how psychological/psychiatric health care is organized create a situation where some asylum-seeking children may get specialised help while others do not.

At the time of the fieldwork all, except one, of the UAM at Erikslust were seeing a psychologist. The staff is of the opinion that this is an important intervention, and that the youths also express the usefulness of having a psychologist to talk to. But not everyone agrees: "When I talk with a psychologist about my painful memories it only makes me think about how everything was. It is better to let me be, to let me forget it" (interview with UAM).Whether we see an intervention as helpful or not depends on many things, but among them are both personality and culture. Hjern & Jeppsson refer to studies with divergent effects of talking and working through war experiences, and conclude that "(…) the effect of a working through program in one context cannot automatically be translated to a different population with a different cultural discourse for dealing with painful memories" (2005: 120).

Luxembourg

In Luxembourg asylum seekers, especially victims of trauma, are granted psychological care and follow-up care if needed (Règlement grand-ducal du 8 juin 2012, Art. 1.8). This means that they can benefit from the service offered within *the national health system*. In Luxembourg there is no specific institution or centre to support war-affected or unaccompanied minors; psychological guidance or any treatment in the field of mental health is made by psychologists or psychiatrists (child and youth specialists) working in either private practice, public health system or in other organizations/associations within the domain of mental health, such as mental health centres (these centres are run by non-profit organizations and receive public funding). Within the department of Migrants and Refugees of the Red Cross, there is no specialised staff to work with traumatized children; however, children in need of transcultural psychological care, psychosocial support as well as pedopsychiatric care may benefit from the project *Eng Bréck no baussen*, of course with the permission and involvement of the parent of the child. The program is indeed created primarily for the care of adults, but unaccompanied minors or children are surely not excluded. In general, the Red Cross (Migrants and Refugees department) works closely together with internal and external partners, such as the Hospital Centre (Centre hospitalier), the Pediatric Hospital (Hôpital pédiatrique), the psychiatric service for children and adolescents (Service pédopsychatrie) to ensure expert care for this very specific population and their very specific needs (E-mail correspondence with Red Cross staff).

As no identification procedures exist, there are no statistics or even estimations on the number of war-affected children currently living in reception centres in Luxembourg. There are some families from currently war-affected countries like Syria, so with them it is highly probable that children have witnessed violent situations. As already mentioned, employees of Caritas and OLAI stated that they were not able to help with this research project, due to a lack of experience with war-affected children. The professionals and experts of the Red Cross and ORK related in the interviews that they would rather use a broad definition of the term 'war-affected'. To their assessment, not only children who have directly participated in or witnessed acts of war are affected by this, but also children whose families have been

traumatized during a war maybe 15 years ago, such as in Kosovo, still show symptoms of psychological distress. Due to the transgenerational transmission of traumatization, they also might be defined as *war-affected*.

4.7.3 Psychological and psychiatric care to parents

How war-affected children cope is not only dependent on their personal exposure to traumatic events but also dependent on their parents' exposure and coping with war traumas (Montgomery & Linnet 2012*;* Godani et al. 2008). Normally a child would turn to his or her parents for comfort and support but when the parents are traumatized they are often pre-occupied with their own problems and less sensitive and able to meet the needs of the child. In other words, they may be emotionally and functionally unavailable to their children. Research from Sweden shows that 87 % of children with traumatized parents show disorganised attachment - "(…) caught between a desire for nearness and a fear of approaching the parent" (Daud 2008: 8) – while 75 % of the children with parents who are not traumatised had a secure attachment (Ibid.). Both Daud's (2008) and van Ee's (2013) research stress the risk that parents may transmit/transfer their unprocessed traumas to their children. There is also a risk that violence within the family sphere, either between adults or adults' violent behaviour towards the child, may be more frequent in families where one or both parents are traumatized or suffering from other forms of psychological problems. As expressed by Montgomery: "Quite a lot of violence in families is related to PTSD in the adults". In Norway, 20% of the incidents of physical violence in asylum centres are domestic violence[23] (Proba samfunssanalyse 2014: 10). Based on this, and several studies confirming the same, we cannot ignore that children's psychosocial well-being is affected by parents' traumatization, and therefore we cannot ensure the realization of the child's right to rehabilitation without extending the right to treatment to their parents, also to parents' whose asylum application has been rejected.

As noted above, while asylum-seeking children under the age of 18 have the same right to health care as other children in all the three case countries, this is not the case for adult asylum seekers. In Sweden adult asylum seekers only have the right to acute treatment ('health care that cannot be postponed') by general practitioners or at the emergency room, while asylum seekers in Denmark and Luxembourg have the same access to medical treatment as everyone else. According to the Danish Red Cross, there is always an assessment of the need for psychological counselling and most traumatized adult residents get psychological counselling or are referred to a psychiatrist. Traumatized parents may get psychological or psychiatric care based on their own needs or based on the needs of their children (interview with social curator). The right to psychological and psychiatric care does not depend on the status of the asylum application. Rejected asylum seekers have the same right to treatment (interview with social curator).

[23] May also be called family violence and encompasses, not only violence between adult family members, but also inter-generational violence and abuse. Children may, hence, be the direct victim of violence or a witness to violence towards other family members.

4.7.4 Good practices regarding Psychological support

Cross-culturally sensitive psychological support (Luxembourg)

The cross-culturally sensitive psychological support program, *Eng Bréck no baussen*, is set up in the first reception centre for asylum seekers, allowing swift recognition of a problem and a quick response to the needs of the person. This support program aims to:

- provide cross-culturally sensitive psychological support adapted to the individual needs of asylum seekers suffering from severe and persistent mental health problems
- provide answers to allow ill asylum seekers to acquire new life skills adapted to their mental health needs and their life in communal structured housing
- establish a network and cooperation with the mental health care system in Luxembourg with the goal of an occupational and socio-therapeutical rehabilitation program outside communal structured housing (Red Cross EU Office 2012: 2).

Given the offer of this service, the personnel of the reception centre is aware of the wide-ranging issues involving mental health problems, with the reassurance of knowing who to go to for assistance and advice. However, the transcultural support and care of the person continues during the stay in other centres, mainly in Red Cross centres, but the psychologist continues to work with many of the people transferred to state- or Caritas-run centres for asylum seekers. *Eng Bréck no baussen* offers and organizes mental health support to asylum seekers on three levels: (1) on an individual level, (2) on a group level (based on asylum seekers living in communal structured housing) and (3) on an occupational rehabilitation and social integration level (Red Cross EU Office 2012: 2). The program was initially installed for adults, but also some UAMs and children with families benefited from it. Initially designed for intensive support to 8 to 12 people, it quickly became apparent within the first year of the project, that the demand and need for culturally sensitive psychological support was much higher than anticipated in the first estimations. Since the existence of this specialised program, a lot more asylum seekers with the need for psychological and psychiatric treatment are detected (also due to training and greater sensitivity to the issue from the staff in the centre), but the professionals state that they are sure that still a lot remain undetected, including war-affected children.

A psychologist is present in the first reception centre and in case of psychological distress (or any other manifestations of mental health issues), he or she can be addressed by asylum seekers, their families and room-mates directly, without waiting times. Staff at the reception centre, including security personnel, is more sensitive and aware of the difficulties and specificities of mental health issues. Staff members (social and technical staff) also direct asylum seekers to the psychologist, if residents of the first reception centre show symptoms of psychological distress or mental illness. The psychologist makes an assessment of the person's needs and demands concerning their mental health: the help sought and care installed ranges from medical attention, psychiatric or psychotherapeutic attention or other psychosocial-educational support, and is then responsible to install care. This care may be short term, long term or even very long term, up to several years. Given the many and very varied mental health problems and personal needs for support, combined with the often

unknown duration of stay in Luxembourg, three types of cross-culturally psychological support are offered to asylum seekers: (1) Long-term support and care to beneficiaries suffering from severe and persistent mental health problems: these cases are followed up and supervised by the Admission and Managing Committee (AMC) every three months. (2) For a 2nd group of beneficiaries, a cross-culturally sensitive psychological support was needed to ensure, via cross-cultural communication, the continuity and quality of a treatment prescribed by a doctor: to "translate" the need for treatment, to help the person in need to understand, accept and continue the therapy. The period of time needed for this support varied with the treatment (from weeks to several months). (3) A 3rd group of participants were in need of short-term and urgent intervention – crisis management, adaptation problems…etc.

Central to this program is to elaborate a joint course of action with the asylum seeker, taking into consideration and highlighting the person's capabilities, interests, goals as well as education and culture. The theoretical framework of *Eng Bréck no baussen* combines a cross-culturally sensitive psychological support, and concepts and working methods from medical anthropology, all client-centred approaches: the perception and understanding of the person is holistic. In the interview, the psychologist states that the early detection and treatment might help prevent and lower cost because, if undetected, conditions might become more chronic and hospitalization more often necessary, not to mention the enormous and very serious human suffering involved. In addition, the existence of immediate support not only helps the person concerned, but also helps to calm stressful situations and the atmosphere in general in the centre, for residents and staff alike.

FriRum (Denmark)

The starting point of the Danish Red Cross' project *friRum in the Asylum phase* is the experiences from a previous friRum (meaning *free room*) project (2009 to 2011) aimed at refugee children and youth. The project was a collaboration between Red Cross and Landsforeningen SIND's next of kin counselling program (Petersen et al. 2011). The approach was methodically based on an innovative coupling of SIND's experience and practice of kin groups for children and young people, and the Danish Red Cross' experience with psycho-education of vulnerable refugee children and the play-based method of *Joyful Play*. The overall objective was to develop and test a distinct and targeted effort to improve the living conditions of children (8-18 years) in refugee families affected by PTSD (Ibid.). The project sought to prevent the psychosocial problems, such as loneliness, isolation, concentration difficulties and poor performance in the education system.

While the first friRum project was implemented in the municipalities, targeting refugee children in families with residence permits, the current friRum project is developed further to address the situation of children in the asylum-seeking phase (interview with friRum project leader). The aim is to improve children and young persons' psychosocial well-being and resilience through the participation in what can be likened with peer support groups. Currently the project targets children from 6 to 16 years. The children are divided into age groups; 6 to 9, 10 to 12 and 13 to 16 (interview with friRum project leader). The previous friRum for settled refugee children had 12 group sessions and 2 family gatherings, while the number of sessions has been reduced to 8 in the project targeting asylum seekers; reasons being the instable life

situation and frequent relocations of asylum seekers. We note, however, that the original friRum handbook recommends a minimum of 12 group sessions as this will better enable trust-building and ensure best results for the individual child and the group as a whole (Petersen et al. 2011).

The team facilitating the group sessions consists of one psychologist and one educator (pedagogue). The educator is a teacher at the Red Cross school and hence knows the children already. The educator is the one selecting the participants, based on who he or she thinks will benefit from being part of friRum and who he or she thinks may function well together as a group. In the groups the children work with themes such as stress, emotions, identity and their resources through stories, exercises, music and games. Examples of activities in the group sessions are: 1) Each child cuts out a tree and leaves to put on the tree. The tree symbolizes his or her life and the leaves are people who are important to him or her; 2) A full body drawing is made of each child who is then asked to place different emotions and feelings on the body. Activities are adapted to individuals in the group (age, personality, psychological distress etc.) as well as to the group dynamic.

The group sessions build a better self-understanding, build resilience and build peer support and social network. At the same time, professionalism is ensured through the leadership of the psychologist and the educator. The project leader of friRum expresses that these groups are "(…) a great way to reach children and families with professionalism without seeming scary", referring to the fact that some find it difficult to talk with a psychologist as they are of the opinion that only mentally ill people need to see a psychologist.

The group sessions take place either in school or at children and youth clubs. With regards to unaccompanied asylum-seeking minors the groups take place at the centre. FriRum also addresses parents and the rest of the family. In the two family events that are organized the psychologist is responsible for a lecture/talk on topics that aims at raising awareness and knowledge about trauma. According to the project leader the choice of location plays a role in child and parent attendance. When the groups and the family events are organized at the school, there is a better attendance among children but parents' attendance at the family event is reduced. Attendance by children is reduced when gatherings take place in the clubs, while attendance by parents is increased (interview with friRum project leader).

The future goal is that children group sessions can be offered to all children in the Danish asylum centres. SocialRespons conducted a mid-term evaluation of the project 'friRum in the asylum phase' in 2014 (SocialRespons 2014). This evaluation was based on limited data and the final report due 2015 will contain more findings. This mid-term evaluation, nevertheless, reports that 67 % of the children said they learned things that improved their situation in school and at home, and 72 % of the parents felt that the sessions had a positive influence on their children`s well-being (Ibid.: 12). The results with regard to the exact aims, however; if the children felt better, if family life had improved, if they felt better in school and if life generally had improved, fewer children said that their situation had improved. The difference between the results might be related to how the children understood the questions. The evaluation also focuses on the difference between arranging sessions at the asylum centre and

in school. It is argued that the centre model includes more opportunities to create a free room, split into specific groups and involve parents. In addition the mid-evaluation highlights the importance of cooperation between psychologists and teachers/ pedagogues, and good preparation.

Family-focused psychological support (Denmark)

As earlier argued, how war-affected children cope is also dependent on parents' exposure and coping with war traumas. Red Cross Denmark has experience in family-focused psychological support through their collaboration with Solvita. As mentioned in a former chapter, Solvita includes a variety of professional disciplines - psychologists, music therapists, acupuncturist, social educators and mentors – who work jointly to solve the psychosocial tasks. Their staff is multicultural and therefore also fluent in the mother tongue of children and adults at asylum centres. The family-focused support combines a bilingual social educator and a music therapist. Often the psychosocial well-being of the child shows signs of improvement after only a few sessions. Focus is both on the child's well-being and building parental skills. The support measure addresses the child's well-being through music and creativity, and aims at building the parenting skills of the adults by helping them understand the reactions of their children and work on how they can avoid (or minimize) that their own mental stress and traumas affect their children. Although the measure is family focused, the decisive factor to initiate any of the above mentioned measures is that the child has some kind of problems; it being sleeping problems and nightmares, behavioural problems (silence/isolation or violence), he or she refuses to go to school, does not dare to leave his or her parents' side, or if the child appears to be suicidal. The social curator believes the good results are linked to the competence that the Solvita personnel represent. Those benefitting from this support measure become better at handling and coping with their problems. "This is important regardless of whether they stay in Denmark or are returned home" (interview with social worker).

Parents interviewed at Avnstrup also hold the view that the music therapy combined with a social educator is a fruitful method. However, what they value the most is what is called a *support person.* This person spends time with the family, often several times a week. The two interviewed families have a support person visiting three-four days a week, each visit lasting for several hours. This measure has a family focus as well, and individuals that speak the family's mother tongue. The support person spends time and talks with each child separately, building a relationship based on trust. Parents get help adjusting to the new society and new parenting norms. In addition, depending on the child's needs, the support person may have particular skills, for instance, related to talking about trauma or knowledge of relaxation exercises to help the child fall asleep at night. The support person measure is not only used for children in families but is also a support offered to UAM. A father argued:

> The best support you can give to war-affected children is adult support, like we have gotten through the support person. Our support person knows our children better than we do ourselves. They talk more openly about everything with him than with us (interview with father).

4.8 Representative/ Guardian for UAM

All the three case countries have a system of a legal guardianship specifically earmarked for unaccompanied children seeking asylum. There are nonetheless some variations in the three systems.

Denmark

In Denmark there are two types of guardianship; one for the asylum-seeking phase and one for those who obtain a residence permit. When an unaccompanied minor is seeking asylum he or she is appointed a *personal representative* ('repræsentant'), while a *legal guardian* ('midlertidig forældremyndighedsindehaver') will be appointed if he or she is granted asylum. The representative is appointed when the child's age is determined. In the first meeting with the authorities an *observer* ('bisidder') will accompany the minor. In addition to safeguarding the interest of the minor during the asylum case handling, the tasks of a representative include taking care of the child's interests in relation to other authorities and organizations, making decisions together with the child concerning general personal circumstances, ensuring that the child understands his or her own situation and staying informed about the child's situation and well-being. Danish Red Cross is responsible for recruiting, training and supporting the personal representatives. The majority of representatives are volunteers, but if human trafficking is suspected, the young person has committed a crime or the UAM's case is of a particularly difficult character, a professional representative may be appointed. This will normally be an employee at the Danish Red Cross. At the time of the fieldwork, Red Cross employees also represented UAMs without any specific difficulty as there was a lack of volunteers (email correspondence with Danish Red Cross 19.11.2014). The insufficient number of volunteers was due to a sudden increase in UAMs and new centres, and the Red Cross is about to expand their volunteer network. Usually the appointed representative is responsible for only one child at a time (Save the Children Denmark 2011). In some cases the representatives continue as the minor's legal guardian if a residence permit is obtained.

The impression based on interviews, however, is that the representatives normally have responsibility for many children and youths, and it cannot be said that they have a special support function beyond their legal responsibilities. As expressed by one of the interviewees: "It would be good if the representative also was supposed to provide social support and help with the integration" (interview with UAM). The minors interviewed value having an adult to talk to, but none of them saw their representative as such a person.

Sweden

In Sweden there are also two types of guardianship. After the asylum application has been registered the Application Unit will apply for a *custodian* ('*god man'*) for minors arriving without an adult caregiver. In addition there will be appointed a *public counsel* ('*offentlig biträdet'*), a lawyer of profession, that will assist the minor with the asylum application and accompany him or her in meetings the Swedish Migration Board. The custodian will also accompany the UAM in meetings regarding the asylum case but has in addition the right and obligation to determine all matters concerning the child's affairs, personal as well as economic and judicial. The custodian should have "(…) regular contact with the child, the home where

the child lives, the public counsel and the school or training the child/youth participates in" (Socialstyrelsen: 2013a: 99, authors' translation). He or she should also be in contact and collaborate with the Social Service. These contacts should keep the custodian informed of the young person's situation, and if necessary the custodian should implement measures to improve the situation of the minor.

The law states that a custodian should be experienced, upright (*'rättrådig'*) and otherwise suitable for the task (Rättsnätet 2005: § 4). In assessing whether the appointed is suitable for task, the chief guardian (*överförmyndaren'*) should give special attention to the vulnerable situation of the child (Ibid.: § 4). The impression from the interviews at Erikslust is that the custodian is involved in the legal issues and follows up progress and/or challenges at school. The youths interviewed in this study state that the custodian is only responsible for practical matters and is not a person they would open up to.

Luxembourg

In Luxembourg, all UAMs are provided with a legal Guardian. Normally, the organization running the reception centre where they live (Caritas or Red Cross) takes over the legal guardianship. To do so, the organization applies at the family court. If the young asylum seeker's state of being underage cannot be proved by any identity documents, the judge or the Ministry of foreign affairs orders a medical examination for the 'age detection'. The form of the medical examination is strongly criticized by the ORK (ORK 2013: 48). If minority is approved, the legal Guardianship will be approved by the court. In addition to the legal Guardian, every UAM is supported by an *administrateur ad hoc*. This person, often a lawyer, helps with the requirements of the asylum procedure.

5 The Norwegian Context

The transferability of identified good practices in the case countries to the Norwegian context is of great importance. We, therefore, find it appropriate to include a general description of structures in the Norwegian society that are relevant for psychosocial support to asylum-seeking children. We provide some examples at regional and local/ municipality level on structures of psychosocial support that are available to war-affected asylum-seeking children. Through interviews with four professionals in Sandnes municipality working at these levels we got an impression of the relevance of good practices that were identified through the case studies in Denmark, Sweden and Luxembourg. We would like to highlight that these are only examples as we did not aim at a thorough description of the whole Norwegian system, as there will be variations from municipality to municipality (for a more general overview of the Norwegian asylum system see NOU 2011:10; on refugee and asylum-seeking children see Meld.St. 27 (2011-2012)).

At the end of the chapter we will present a description of some relevant features in the structures, resources and rehabilitation measures Norway provided to support youth survivors of the terror attack that took place in Utøya on 22 July 2011. After the terror attack Norwegian authorities decided to replace a *watchful waiting* approach with a *proactive follow-up* (Kärki & Weisæth 2014). We could probably learn from this experience to implement more proactive follow-up of war-affected asylum-seeking children in Norwegian mainstream health structures. Even if the context of the Utøya survivors and asylum-seeking children and youth is different, it is relevant to see which measures implemented after July 22 can be activated also when it comes to war-affected asylum-seeking children. Our concern is to build on former experiences to put in place new measures from a national level and in the mainstream system as the youth in need of support after the terror attack at Utøya came from the whole country.

5.1 The situation and rights of asylum-seeking children in Norway

5.1.1 Accommodation

The accommodation of asylum seekers during the application period is organized through asylum centres throughout the country. The Norwegian asylum system consists of transit centres, ordinary asylum centres, care centres for unaccompanied minors less than 15 years of age (operated by the National Child welfare services), reception centres for unaccompanied minor asylum seekers above 15 and reinforced units for residents who need special follow-up. There has, in recent years, been an increase of decentralised residence facilities in ordinary residential areas. Many but not all families with children live in such decentralised apartments. Although decentralised residence facilities are preferable to centralised centres, both alternatives are often characterized by cramped living conditions (Lidén et al. 2010).

Children below the age of 15 have been under Child welfare services (CWS) since a reform in 2007 (Stang 2012: 144). This was acknowledged by the Committee on the Rights of the Child in their 2010 report to Norway (Ibid. 154). However, they were concerned about the care given to these children and they recommended that also children aged 15-18 should be under the responsibility of the CWS. According to Vaage there is a need for a more harmonised approach to accommodation of UMs above the age of 15 in Norway (interview with Vaage). Different models are chosen in different municipalities. Children from the age of 15 live in UAM-homes which are voluntary accommodation centres, but not care centres, something the UMs need, as they are alone, without families and network. In line with Sveeass et al. (2011), Vaage emphasizes that there are too few resources at UAM-homes in Norway and there are too few employees to care for the children and youths living in such residence facilities.

Elisabeth Gording Stang (2012:155) argues that a main challenge to ensure children's rights is the lack of coordination and cooperation between different institutions. Vaage gave an example of how confusion regarding roles and responsibilities of different systems for UMs lead to poor care:

> It is difficult for unaccompanied minors to understand the function of the different structures. We once had a patient that was psychotic. He came during the autumn. He had not yet received warm clothes and then there was a discussion while he was in hospital: who is going to provide him with some clothes? In the Department at the hospital they said ´that's parents' responsibility'. The UM centre responded that their responsibility was accommodation, not care. ´We cannot buy clothes'. It's unbelievable! The guardian was unreachable and he had 23 cases. Where is the care for these children? Care, network and attachment are much more important than treatment, which is on the bottom of the needs-list.

Nurses at the health care services for asylum seekers and refugees in Sandnes municipality highlighted calm and safe rooms as one important thing that asylum-seeking children need whereas the reality is often overcrowded conditions with a lot of noise. This does not favour a *sense-of-safety* for children. We were told about a youth that had asked for a calm place, but the asylum centre could not find one. This illustrates that even when these needs regarding accommodation are expressed due to psychiatric conditions, they are not necessarily fulfilled due to the lack of accommodation options.

5.1.2 Education

In Norway children aged 6-16 that are expected to stay in the country for more than three months have a right and a duty to attend primary school (NOU 2011:10: 237-238). Host municipalities are to ensure this education and receive some financial support in order for the children to start school as soon as possible (Ibid.: 344). This support can also be used to educate 16-18 years olds without primary education, but this is not formulated as a right. Asylum-seeking children between 16 and 18 years are entitled to secondary education until their asylum application is rejected or the end of the school year when they turn 18 years (Education Act § 3-1(12)).

There are many variations as to how municipalities arrange education for asylum-seeking children (de Wal Pastoor 2012: 222-224, Lidén et al. 2011: 79). In general there are four models. In *ordinary classes*, children attend local schools with other children living in the area. In addition to ordinary classes they may receive language classes. In *special reception classes* the children are taught in separate classes at the local school or at another school in the municipality. The intention is to teach the children Norwegian and when they master the language they are transferred to ordinary classes in local schools. *Combined classes* provide education to the children in ordinary classes at the same time as they receive some special training, especially in Norwegian, but also in bilingual education and their mother tongue. *Special reception schools* are separate schools for newly arrived asylum-seeking children that provide special education within a limited time before the children enter into ordinary classes.[24] The most common model is ordinary classes, or a combination of reception and regular classes. There are both positive and negative sides to these different models. Ordinary classes promote better social networking with Norwegian children, but at the same time they can be less adapted especially with regard to language use. On equal terms with the population as a whole, asylum-seekers are entitled to an adapted education. This continues, however, to be an important challenge for teachers and schools (de Wal Pastoor 2012: 224).

Children in asylum centres have no right to attend kindergarten, but children between 2 years until primary school age should attend facilitated services at the centre for at least three hours a day Monday to Friday (NOU 2011:10: 239). From 2002 financial support, administrated by the UDI, was allocated to part-time attendance of four and five year old children in kindergartens, and from 2011 support was given to full-day attendance to this group. On UDI`s webpage it is stated that four and five years old children should, as far as possible, be given an offer of full-day kindergarten (UDI 2015). UDI covers the kindergarten fees (parent's contribution) for asylum seeking children from 4 years of age.

5.1.3 Health care

Asylum seekers have the same rights as the rest of the population to health services (NOU 2011:10: 220). Providing health services for asylum seekers relates according to the guide on health services to asylum seekers and refugees published by the Directorate of Health in 2010, to the different phases of the asylum-seeking process: transit, ordinary phase and return phase (Helsedirektoratet 2010). Asylum seekers are first placed in transit centres where they stay until they are registered, have received a health control including a mandatory tuberculosis screening and have completed the asylum interview. The health services at this stage can be considered as specialised health services (NOU 2011:10: 221). Asylum seekers are placed in ordinary asylum centres during the period that their application is being processed and until they are settled in a municipality of residence or returned (Helsedirektoratet 2010: 12). While in ordinary centres it is the host municipalities that are responsible for primary health services. Where necessary they refer patients to specialised health services ensured by the regional

[24]See for instance Johannes læringssenter in Stavanger (http://www.linksidene.no/minskole/johannesg/pilot.nsf/ntr/F727E435C44D226CC125783E00356972?opendocument&u=Innføringsskole)

health structures. The rights to health services change when asylum seekers find themselves in the return phase with a rejection of their application. At this stage children continue to have the same right to health services as other children in Norway, while adult asylum seekers are entitled to emergency assistance but not specialised services.

Municipalities can freely organize health services within the relevant legal framework, and they are urged to take into consideration that people might have been victims of torture or other forms of traumatizing events (Helsedirektoratet 2010). According to the guide published by the Directorate of Health in 2010 contact should be established as soon as possible, and preferably within two weeks after the arrival at the ordinary asylum centre, between the asylum-seeker and health services in order to assess health conditions and eventual needs for health services (Ibid.: 27-28). In addition to a medical examination there should be a conversation with a nurse so asylum-seekers and health personnel may establish contact and asylum seekers can be given information about health services in the municipality. It is important, according to the guide, to raise questions about traumatic experiences with possible physical and/ or psychological consequences during the first meeting. The guide further suggests that a long-lasting treatment for less serious conditions should not be initiated unless it is considered to present a risk of significant deterioration of the health status.

The guide acknowledges that asylum seekers meet certain barriers to attain equal health services, such as booking an appointment, language, culture and the structure of the system (Ibid.). There are also some challenges connected to the so-called D-number (social security number), which asylum seekers need in order to be put on a list to get a general doctor (*fastlege*) and which in some cases takes some time to get. The guide argues, however, that asylum seekers should get a consultation with a doctor even without the D-number. It is also recognized that some municipalities need to employ specialists in order to specifically take care of asylum-seekers and refugees. Employing health personnel at the asylum centres is, however, not recommended since this could obscure the principle of the sectors. Doctors in neighbouring areas, that are used by the population in general, are presented as the best option.

5.1.4 Identification of vulnerable asylum seekers

Sveaass and colleagues (2012) describe the different stages in the asylum process in the Norwegian context where vulnerable asylum seekers might be identified and registered. They note that the most important thing, within the practice in Norway, is that vulnerability and special needs can in fact be identified at different stages and that different professionals are included amongst those who can effectively detect whether there are any special needs or problems that should be further investigated (Ibid.: 90-91). The *registration of the asylum application* is the first opportunity of identifying somatic circumstances. However, the purpose of the interview does not give a lot of room for identifying vulnerability. The more thorough *asylum interview* at UDI is, on the other hand, a more important source of information. Since clarification of the need for protection is central in these interviews, stories of potential traumatic events might come up. In group sessions with newly arrived asylum seekers and volunteers that are sometimes organized in *transit centres*, problems might be identified and reported to the system. Physicians at the transit centres can be contacted if there

are any acute health issues, whereas other issues will be referred to the health checks offered at the ordinary *reception centres*. Sveaass et al. note that this can be an opportunity for identifying people that might need a follow-up, including health-related conditions that are significant for further placement (Ibid.). The Norwegian Organization for Asylum Seekers (NOAS) is an independent organization working to protect the rights of asylum seekers in Norway. The authors stress that this organization is in contact with asylum seekers when giving them guidance and information, and that they have the possibility of sending a *report of concern* to the health services. Optionally the asylum seeker can be urged to convey health issues themselves to health professionals.

Despite several avenues for identification of special needs, Sveaass and colleagues stress that as long as there is not an explicit focus on this or clear guidelines beyond necessary short-term follow-ups, it is likely that individuals with needs are not identified during the asylum process. Sveaass et al. also note the importance of access to and confidence in interpreters as an important factor to identify vulnerability, and stress the importance of forwarding information about vulnerability and special needs between the different bodies when asylum seekers are transmitted from one reception centre to another.

5.2 On a regional level: specialised health care services

Four regional psychosocial teams for refugees and asylum seekers existed until 2004 (in the south, west, middle and northern part of Norway). The Psychosocial teams were created based on an experience at Vinderen psychiatric clinic in Oslo developed by Prof. Edvard Hauff, Prof. Nils Johan Lavik and Nora Sveaass in the late 1980s.[25] Following this, a centre called The Psychosocial centre for refugees (PSF) was created at the University of Oslo in 1990 led by Lavik. Prof. Sverre Varvin was Senior Consultant and the centre had 4-5 clinicians in addition to other staff. Their occupations were treatment, rehabilitation, teaching and research, and they gave comprehensive guidance to second line psychiatry services. The four regional psychosocial teams for refugees and asylum seekers were created and connected to it in kind of a network where PSF functioned as a mother centre. According to Varvin the centre had good collaboration with the four regional teams and the structure functioned well. It was considered by primary and specialised health services as a place they could seek advices and support. It was also known among refugees to be a place where they felt safe, according to Varvin.

PSF was closed in 2004 due to a reorganization process, led by the Directorate of Health (Ibid.). The Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS) was established in order to strengthen knowledge and competence regarding violence and abuse, refugees, catastrophes and traumatic stress (Helsedirektoratet 2010: 11). NKVTS does research and consultation, but does not have clinical treatment. At the same time Regional Resource Centres for Violence, Traumatic Stress and Suicide Prevention (RVTS) were established in order to give guidance to professionals, including those working with migration.

[25] Email correspondence with Prof. Sverre Varvin, Oslo and Akershus University College of Applied Sciences 28.01.2015

These centres have, according to a guideline of the Directorate of Health from 2010, a professional team within the area of refugee health and migration that should contribute with teaching, consultancy and multidisciplinary collaboration. Employees at PSF protested against closing the centre and the regional teams. Refugee patients lost a specialised centre where they could receive treatment, and guidance to the mainstream system based on both clinical work and research disappeared. This reorganization is, however, part of a larger political discussion about providing asylum seekers and refugees specialised health services or include them in the mainstream system.

In Stavanger, on the West coast of Norway, a new centre has opened called *the Transcultural centre*, with support from the regional health authorities (Helse Vest). The centre is a collaborative project between adult psychiatry and child-and adolescent psychiatry, formally administered by the Department of Child and Adolescent Psychiatry at Stavanger University Hospital. The main aim of the centre is to provide specialised mental health services for war-traumatized and tortured asylum seekers and refugees:

> (…) to contribute to giving asylum seekers and refugees equitable mental health services. We collaborate closely with important actors working with refugees: Primary health service, second line health services, asylum centres and refugee services in the municipalities. Cooperation with civil society organization will also be relevant (Helse Stavanger. Stavanger Universitetssjukehus 2014, author`s translation).

The Transcultural centre is a two-year pilot project. The centre has been planned for several years and started in August 2014. It is unique in its form in Norway, but has been inspired by the earlier Psychosocial centre for refugees in Oslo, and by exchanges with colleagues in Scandinavia as well as internationally. A family-focused approach in dealing with traumatized children is an important focus, and treatment is accessible to all ages, according to Aina Basilier Vaage, who is, as a child psychiatrist, one of four therapists working at the centre (interview with Vaage). The centre is open to all regardless of their residence status, with or without legal stay in Norway. The centre is intentionally located in a building away from the hospital area so that it is considered less stigmatizing than going to the Department of Psychiatry. Vaage argues that it is an advantage to be an interdisciplinary team working with these kinds of difficult issues and stories. The other therapists are an adult psychiatrist, a clinical social worker and a psychologist.

The Transcultural centre is a clinical competence centre, working with referred patients as well as offering consultation, counselling and teaching to others working with refugees and asylum seekers, such as asylum centres, refugee services and municipalities. The therapists are also available for assisting clinical personnel in patient assessments and treatment. It is crucial that this centre provides both clinical work with patients, consultation and research. Colleagues at the psychiatric division may refer patients to the centre and exceptionally, the centre receives patients directly from primary health services or others meeting refugees and asylum seekers in need of help, if other sources for help have been insufficient. To increase accessibility is an important goal for the centre. If patients are afraid to come to the centre, e.g.

due to stigmatization related to mental illness, the therapists may meet the patients where they live or feel safe, for example at their school.

The background for the establishment of this centre was research findings and clinical experience showing that people from non-Western cultural settings may have great problems accessing the specialised mental health services, and have more serious conditions at referral compared to Norwegians. Vaage refers to barriers such as language and often a lack of trust in interpreters, lack of knowledge of the Norwegian system, stigmatization connected to seeking psychiatric help, stereotyping of the patient group in the health system, the possibility of misdiagnosis related to lack of knowledge of the role of culture in mental health, and not least the vulnerable situation of asylum seekers and refugees due to their past and the asylum phase. Both adults, UAMs and children arriving with their parents meet these different kinds of barriers. Vaage argues that often asylum-seeking children arriving with their families do not get help as their parents might have to cope with their own problems and lack of knowledge about the system. In addition many children are careful not to share their problems with their parents, as they want to protect them.

The centre is commissioned by the regional health authorities to develop methodologies in assessment and treatment of traumatized and tortured refugees and asylum seekers, to reduce barriers to mental health services and increase accessibility, working with a human-rights perspective. According to Vaage, there is need for such a centre, offering culturally competent psychiatric services with knowledge and awareness concerning the specific challenges meeting asylum seekers and refugees. She has seen examples of misdiagnosis due to lack of competence in cultural awareness, as traumatic experiences or culture all too often become the only explanation for the patient's problems. For instance challenges among children suffering from problems related to neuropsychological defects, explained as being due to multilingualism alone, and children suffering from autism being diagnosed as traumatized, with no assessment of other conditions. For all refugees and asylum seekers there is a need for extra awareness and proper assessment, with a focus on cultural factors, migration and refugeedom in order for equal health services to be fulfilled.

The refugee and asylum-children often have combined problems related to traumatization and attachment problems. They may also have additional challenges in that they often have war and war-related experiences, being uprooted from their society and networks of friends and family. Living with traumatized and anxious parents adds to this, and trans-generational transference of trauma is an important problem and focus of discussion. This adds to the problem of attachment. In addition it is necessary to be conscious about the fact that trauma may also be experienced by a person within his or her socio-cultural context. How a person, and a child, reacts and how trauma is perceived is individual and relates to many factors, one of them being the socio-cultural context of the person, both before and after the flight.

5.3 On a local level: health care, education and recreational activities.

Host municipalities have responsibilities towards asylum-seekers based on sector responsibility (*sektoransvar*) (NOU 2011:10: 125). This means that competent authorities, sectors and administrative levels are as responsible towards asylum-seekers, as towards the population in general, to ensure that they have access to public services. Legally obliged services include Primary health services, Child welfare services and Primary education whereas Norwegian language education and kindergarten for four and five year olds are services that municipalities are not legally obliged but expected to provide.

5.3.1 Health services for asylum seekers and refugees

In the Municipality of Sandnes there are facilitated health services for asylum seekers and refugees providing for example welcome conversations, information about health services and rights, and help to get in touch with specialised health services if needed (Sandnes Kommune 2015). In relation to this project we interviewed two of the nurses attached to these services. They work in close collaboration with the Child and Adolescent Psychiatric Out-patient Clinic (BUP) Sandnes and now the Transcultural centre in Stavanger when it comes to psychiatric cases that demand specialised services. The nurses were of the opinion that the existence of the transcultural centre made it easier for them to get immediate help from a psychiatrist when they needed this kind of professional support. The fact that the Transcultural centre was connected to the hospital made it possible to find ways in the larger system. Because the centre was easily accessible, they felt that they had the capacity to help children in need of psychiatric support. In addition, they hoped that the centre through its teaching activities could reach Norwegian primary health-services with information and awareness on the rights of asylum seekers. Convincing institutions and health workers about the rights and needs of asylum seekers was raised as a challenge.

Employees at the health care services in Sandnes focused on welcoming new asylum seekers through, among other things, welcome-conversations with the children and their parents. These conversations give them an impression of how the children and their parents relate to their past themselves if they are willing to talk about it. Often, newly arrived asylum seekers do not want to enter into these kinds of conversations, but an important aim is to raise awareness. The employees want to show asylum seekers that they are aware of their situation and possible challenges, and that they can help them if needed. Vaage argues that therapy focusing on traumas is not recommended for children in an asylum-seeking period because they are still living in a traumatic situation. The main focus should be to help them stabilize the often overwhelming feelings, to establish a feeling of safety and to build trusting relationships. In order to start working with traumas, children need to have an organized and safe life situation, and their parents have to be capable to assist, and agree to deal with the traumatic memories of the past. According to Vaage there is, however, little evidence from research that treating asylum seekers or refugees with a focus on trauma works.

The nurses at the health care services for asylum seekers and refugees in Sandnes recommended to develop and implement more groups where children and youth meet to talk, reflect and discuss. They told us about their experiences conducting different kinds of groups (with UAMs speaking the same language and girls from different countries speaking Norwegian together). Through these groups they focus on prevention, arguing that a negative development of painful experiences could be prevented. Every child/ youth participating in one specific group has similar experiences and most have difficulties sleeping because of everything that happened. Regarding UAMs, many have been away from their families for a long time and cannot reach them. To see that their reactions, like sleeplessness, anger, lack of concentration in school, are natural and common, and that these reactions often disappear or decrease after a period of time is helpful, according to the nurses. By exchanging experiences they might help each other to promote skills to master everyday life. One of the nurses argued, for instance, that it would be difficult to split the youth into groups according to where they are in the asylum-seeking phase because it simply is part of their reality: some of them get the permission to stay whereas others are forced to leave the country. On the contrary, conversation in groups gives them an opportunity to talk about these issues as well. Sensitive issues might be raised and it was emphasized that there should be both an educator and a health worker facilitating such group conversations. Vaage argued that this approach was very useful, allowing children to express themselves and learn together with peers.

Narrative or *creative conversation group methods* are well described in a chapter in the book about refugee children and psychosocial work among unaccompanied minors from 2012 (Myrvoll & Lundesgaard 2012). The methodology has been developed over years and aims to strengthen resilience of youth with certain risks, prevent psychological health problems and work with traumatizing experiences (Ibid.: 241-242, 269). The narrative element is very important implicating that the youths together make up a story about a fictive person that resembles themselves. The conversations build a bridge between the past, the present and the future which is important for continuity and identity formation. The methodology also helps the youths to think about their own story and listen to the stories of others, which often creates recognition and mutual respect. The youths develop social skills and psychological growth, according to the authors, and they learn to trust each other and build friendships. The narratives are sad but also tell about survival and determination.

5.3.2 School

School is one place that can, in addition to offering education, contribute to provide social support and network through peers and trustworthy adults for asylum-seeking children. The experiences of Aspervika school, also located in the Municipality of Sandnes, will be described in the following section.

Aspervika school, with special reception classes, has a lot of experience in receiving asylum-seeking children as it was the school closest to a big asylum centre (Dale) for many years. The centre has now been decentralised. The school is known to receive asylum seekers and refugees well, and the social worker at the school was interviewed in relation to this project. The school now has a reception class and four teachers who have gained experience through

many years. The school has acquired good routines when it comes to welcoming new children; the schooling, follow-up, parting and transitions. The social worker highlights the importance of teacher's awareness and cross-cultural competence as important when asylum-seeking children come to the school. The school has a special interdisciplinary pedagogical team with a coordinator, a nurse, the principal and a social worker. They work as a professional forum where they discuss cases. This school also works in close collaboration with BUP Sandnes and the Transcultural centre in Stavanger. The social worker said she would not hesitate to call the centre if she had any doubts about a pupil at the school. If necessary, she could first discuss the case anonymously with the psychiatrist and proceed to involve the parents if she was recommended to arrange a meeting between the child and a psychiatrist. She argued that it was never a problem to get help:

> Easily accessible. They have capacity and time. We just had a pupil who had some challenges, an unaccompanied minor, and together with the health and care services we argued that he was in need of extra support. Then it moved quickly. I think the centre is an important key.

Due to their experiences at Aspervika school they know what to look for in order to detect children who need professional help. Their experiences reveal that asylum-seeking children have very different ways of reacting to war-related experiences, depending on the character of the experience, but also on the socio-cultural environment and the time spent in asylum-centres. Many youths have painful experiences, but manage their lives well without psychological support. "There are a lot of children in need of a normal everyday life. Not to be treated all the time. Have the permission to be a kid. Find laughter, playfulness and joy. Have good experiences", the social worker said.

Aspervika school is very much engaged in making sure that the children are included in social activities after school, such as friendship groups organized by the classes. This is a measure that parents initiate in order to help pupils get to know each-other outside of school. The pupils are separated into small groups that visit each other´s homes. It might be difficult for an asylum-seeking child to receive classmates in the asylum centre, and this is where the attention of teachers and the social worker is crucial to help find other solutions. The same is done with regard to birthday-celebrations when it comes to buying gifts and where to celebrate. To be part of the group, to play and to be included in social activities is regarded in this school as important and of huge value to strive for a *normal* situation for the children. Financial resources are needed, however, in order to give asylum seekers a chance to experience a stable and *normal* every-life, and this should be sought from the first day of their arrival. As an illustration the social worker reveals that the lump sum asylum seekers receive at the start of the process is too low to buy a school bag, warm clothes and shoes. The school usually collects used clothes and shoes in order to have something to give them when they come. They have seen children coming to school in sandals and experienced that parents keep children at home waiting for the date that they receive money.

At Aspervika school they have some experience with recruiting families to take care of and develop an affiliation with families in need of support (Interview with social worker). It was based on voluntarily engagement, very much dependent on the persons involved, according to

the social worker. Not every asylum-seeking family is ready and do not have the capacity to get involved with other people. The social worker would, however, like to try this approach again. Vaage argued that affiliation with others over time is a key factor for a healthy development to take place. The support from employees in institutions is not enough as this is not an affiliation that can last. They are employees in public institutions. If an affiliation is established with a support family or person, this relation can for instance last even after the child reaches the age of 18 and is no longer under the responsibility of the child welfare service. Lacking an alternative network and affiliations, these youths are vulnerable and more easily recruited to criminal networks and drug abuse. With regard to children in families, support from another family can develop an affiliation between the family and society. An important question is, however, how to recruit this kind of support families and whether this needs to be a paid arrangement. Anyhow, Vaage strongly emphasized that attachment and social network constitute the psychological base upon which children and youths build their lives. Friends may last for shorter or longer periods, and making friends might be a big challenge for asylum seekers in their uncertain situation, but they are all important and can make a difference in the lives of these children.

5.3.3 Recreational activities

Since 2006 financial support has been given to recreational activities for children and youth in asylum centres (NOU 2011:10: 241). In 2010 UDI administrated 13.2 million NOK for this purpose; 6.5 million was given directly to the centres and the rest was channelled through organizations that provide activities at the centres. According to a report on recreational activities for children and youth in asylum-centres (Seland & Lidén 2011) these funds contributed to improve already existing activities but did not contribute to extend the range of activities offered. This report also describes that the centres have different strategies when it comes to providing activities for children and youth. Some use already existing activities in the local society whereas others focus on providing activities at the centres.

Asylum-seeking children's need for recreational activities was highlighted by the nurses at health care services for asylum seekers and refugees and the social worker at Aspervika school. "We need more resources", they argued "Recreational activities are stabilizing factors in the uncertain situation of these children". This is an area which seems to have many opportunities for improvement in the Norwegian contexts.

More individual financial resources and also understanding and awareness from local associations and sport clubs are needed. The social worker at Aspervika school revealed that advising asylum seekers and refugees about recreational activities, assessing their interests, making contact, searching for equipment, and also following them if necessary, was part of her assignment. "Some of the children are not used to it", she said, "but when we see that they show interest in certain things that make them relaxed and happy, we try to find activities nearby". Even though it takes a lot of her time, she considers recreational activities as playing a too important role, in addition to school, in creating spaces that gives asylum-seeking children a break from their worries. She adds that many parents have traumas and difficulties in dealing with the situation. Consequently, going home to watch TV is often the alternative,

which is not going to promote children´s development. She is, however, very much dependent on the good-will of other people, friends, neighbours and trainers to facilitate for the children, for instance when it comes to transport and obligations, such as selling tickets in lotteries.

That municipalities could take some responsibility when it comes to awareness-raising regarding the situation of migrants/ asylum seekers, integration and their rights, was raised by the social worker at Aspervika school. In addition, she argued that municipalities should take more responsibility in trying to change attitudes when it comes to a multicultural society and its benefits. It should be approached in a more holistic way and include health- and school institutions as well as associations offering recreational activities. In this way resources in the local society could be found that might help to improve the every-day life situation of asylum-seeking children. If a football coach has a proactive role helping an asylum seeker to find football shoes and bring him in his car when they go to matches, it could make a big difference to this child. One person`s attention, and an attachment with an adult outside of the institutions and in society, might save a child, according to her. It is not given, however, that all parents will accept such help, which of course has to be respected. In reality, however, asylum seekers do not participate out of practical reasons or misconception.

5.4 Experiences of providing psychosocial support related to the Utøya attack

Many of the victims at Utøya on July 22nd 2011 were minors. It is important to note that while the adolescents at Utøya experienced a single war-like event, the target group of this project, asylum-seeking children, might have been exposed to *multiple* war-related traumas prior to arriving to Norway. In addition there are also other important factors differing the two groups such as the strain related to the uncertainty in the asylum situation, potential traumas of other family members (particularly parents), and the rehabilitation and reintegration process that will take place in an unfamiliar cultural context. In addition it should be added that the whole country supported the victims of Utøya whereas asylum-seeking children often are met with scepticism. Many express difficulties in meeting distrust when they tell their stories. In addition they have to prove their age. According to several studies, one of the most important protective factors after having experienced a trauma is support from social network. It is reasonable to assume that war-affected asylum-seeking children having less access to an already existing network and being mistrusted, due to their situation, are correspondingly more vulnerable.

Another difference is that when dealing with the victims of Utøya, the health services and interventions provided both in the acute and post-acute phase were important. When dealing with war-affected asylum-seeking children on the other hand, a more long-term follow up within the primary health service and the specialist health service is more relevant, as time between the traumatic events and the arrival in Norway may vary. Hence, when looking at the organization of the measures (rehabilitation services) that were given to youths after the Utøya massacre, we have chosen to draw upon experiences and knowledge perspectives relating to the organization in the different support agencies in the long-term follow-up.

The Directorate of Health had previous to the terror attack at Utøya just completed its national guide to psychosocial interventions in response to crises, accidents and disasters (Helsedirektoratet 2011).[26] In this guideline the different actors in the municipalities and their responsibilities / areas of operations, including organizational aspects and health professional assessments based on updated national and international knowledge are shed light on. Clinical recommendations are also presented on the basis of systematic reviews of empirical findings, but it is noted that evidence-based findings should also be taken into account where such exists (Helsedirektoratet 2012).

Five intervention principles were presented in the guide (Helsedirektoratet 2011), forming the basis for the Directorate of Health's guide and the recommendations for the acute phase of crises, accidents and disasters with regard to different levels, individual interventions and group and setting-based interventions:

- Sense of safety
- Calming
- Sense of self- and community efficacy
- Connectedness
- Hope

The activated support system after the Utøya attack was based on these principles. Regarding war-affected asylum-seeking children, sense of self- and community efficacy, connectedness and hope are major challenges.

Norwegian authorities had to decide on a number of issues in the days after the terror attack of 22 July 2011. NKVTS is a key institution as the Directorate of Health's advisory board on issues arising from extreme human emergencies as of July 22. The centre was contacted early on for advice on psychosocial crisis management and follow-up of the victims. In addition, they provided advice to health authorities in line with their general mandate. The Centre for Crisis Psychology also provided advice to the Directorate of Health on the organization of help to victims (Helsedirektoratet 2012: 87-88). It should perhaps also be mentioned that the Norwegian Centre for Minority Health Research (NAKMI) set up a working party within the Directorate of Health to deal with the perspectives concerning the minority population in relation to July 22. The asylum reception centres and municipalities were in need of tailored advices to meet the needs of the non-homogenous groups of immigrants who might be affected. The main themes were re-traumatization and that the multicultural community had been attacked. It is noted that the Directory of Health had produced information for immigrant youth generally and for teachers and other resource adults that work with young immigrants (Ibid.: 89).

Following July 22, NKVTS outlined a series of interventions for following-up based on three principles: 1) Use of existing models for health services 2) Proactive approach to victims 3)

[26] The guide is currently being revised. In the new guide lessons learned after July 22, 2011 will be implemented. In addition, the guide will be updated according to new legislation.

Continuity in the follow-up. Following these recommendations, it was considered most appropriate to strengthen the competence that was already built up in the municipalities. The Directorate of Health recommended that follow-up should be based on *established structures* in the municipality and community in general, rather than establishing *specialised care*. Local measures were taken in the different municipalities to assist the youths and their families. Psychosocial crisis teams, consisting of professionals such as doctors, nurses, psychologists, police, pastors and social workers, in each municipality, played a major role together with the primary health care service. NGOs were also key actors in the long-term program (Ibid.: 88).

Another important decision was that the international guideline's advice on so-called *watchful waiting* after a perceived crisis, as recommended by the British National Institute for Health and Clinical Excellence (NICE guidelines) and implemented in the Norwegian guideline, had to be replaced with a more action oriented approach in order to ensure that those who, for some reason, where not capable of seeking help themselves also should be approached and get an offer. A comprehensive, *proactive – active reach out – model* of psychosocial assistance was developed and implemented for the first time in the Norwegian health system (Kärki 2014: 25). It was agreed that an extraordinary situation demands extraordinary solutions.

The proactive model was based on the existing structures around those affected; the social network, the municipality's psychosocial crisis team, the primary health care service and the specialist health service. Local measures were taken in the different municipalities to assist the youths and their families. In addition the intervention model was based on the emergency preparedness of Norway, being based on three principles:

- *the principle of responsibility* - The authority responsible in a *normal* situation is also responsible for prevention, preparedness and implementation in an emergency or crisis situation. Responsibility in a crisis situation generally follows established sector lines. Hence, different actors will take the lead in different types of crises.

- *the principle of subsidiarity* - Crisis should be handled at the lowest level of authority possible. This places important duties on local authorities.

- *the principle of similarity* - The way of organization during a given crisis should be as similar as possible to the ordinary organization. Competence should therefore be within the existing organization.

The implementation of the proactive follow-up entailed that the municipal health and welfare services took the initiative for contact with the victims. It was proposed that everyone should be assigned a *primary contact person*. A dedicated contact person offered one-to-one sessions and continuity in the contact throughout a follow-up period of at least 12 months. It was recommended that the contact person have either health-care or social/educational qualifications and that contact was to be frequent to begin with, for example, weekly, and from then on adapted to personal needs. The focus was on stabilization, practical assistance and support (Helsedirektoratet 2012: 88). If the contact person had professional health competence, an important task would be to coordinate the intervention (Kärki 2014: 29).

NKVTS was assigned the quest of developing a model of follow-up that should ensure that the affected got customized help adjusted to their individual needs. In addition to the principles already mentioned (pro-activity, a primary contact person, continuity in the contact, long term perspective and coordinated help from the different service providers), three standardized mappings/assessments of the functioning of the victims of Utøya were to be conducted during the first year (Ibid.: 29).

After the attack there was a broad consensus amongst the authorities and the professionals that the psychosocial follow-up, in addition to dealing with the actual traumas, should be long-term, broad spectrum and flexible enough to identify individual needs over time. The measures should entail both individual and collective elements, such as group sessions. Even in the collective interventions it was important to take individual differences into account – both in relation to the needs of the affected, but also the differences in the traumatic incidents, affecting differently considering, for instance, the degree of vulnerability (Ibid.: 32). Using the principle of proactivity, the goal was to reduce health related and psychosocial consequences of the terror for each victim. Health promoting processes were to be emphasized so that one avoided pathologising of normal reactions that were expected after such a catastrophe (Ibid.: 19).

In order to identify war-affected asylum-seeking children and reduce psychosocial consequences of war experiences, Norwegian authorities should consider the relevance of the principles that were implemented after July 22. We find that especially pro-activity, a primary contact person, continuity in the contact, long term perspective and coordinated help from the different service providers, are relevant measure.

6 Discussion and Recommendations

The Committee on the Rights of the Child recommended Norway in 2010 to "Carefully identify children affected by armed conflicts among asylum-seeking children and ensure rehabilitation and social reintegration of these children" (UN 2010). Commissioned by the UDI and the Norwegian Directorate of Health, this report has presented inspiration from guidelines and 'best practices' of NGOs and from measures for rehabilitation and reintegration of war-affected children in Denmark, Sweden and Luxembourg. In addition, we have presented examples from different levels in the Norwegian society of institutions and structures working with psychosocial support to war-affected asylum-seeking children. In this chapter we will discuss main issues with regard to this topic followed by *Recommendations* to Norwegian authorities. Recommendations are based on the previous chapters and what NGO and the selected countries believe are fruitful approaches and interventions.[27] The current dominant view of practitioners and researchers with expertise in the field of war-affected children, of which the research team forms part, is also decisive for what is included as good practice.

The good practices and recommendations, with which this report concludes, are regrettably not evidence-based interventions and measures. Similarly to other child protection areas, there is a lack of research documentation on which concrete measures and interventions that generate the most positive outcome. The need for evidence-based interventions for traumatized children is a major current issue in research on war and children (e.g., Kalantari et al. 2012; de Anstiss et al. 2009). Also, more thorough evaluations, involving control groups, and intervention research (see Fraser & Galinsky 2010) will provide valuable and necessary inputs to practice activities.

6.1 Who has the right to rehabilitation and social reintegration?

Based on our review of literature and the view-points put forward by interviewees in this assessment it is our firm believe that *asylum-seeking children who have been victims of, participated in or witnessed acts of war* must be viewed in a broad sense, encompassing both those directly and those indirectly affected by war. As has been emphasized in much literature on war and children, it was also underlined by both experts and practitioners in the three case countries that war and armed conflict affected whole societies. When asked about how they would define war-affected asylum-seeking children, staff at asylum centres and UAM-homes included children from countries like Eritrea, which by most definitions would not be reckoned as a country in war, but nonetheless where the population suffered from massive structural and political violence. Interviewees also underlined the need to incorporate the generations after those directly exposed to war: Children born of parents who have

[27] The recommendations reflect what we, based on the undertaken assessment, consider necessary to ensure war-affected asylum-seeking children's right to rehabilitation and social reintegration. It is outside the scope of this assessment to consider the financial (and practical) consequences of these recommendations.

experienced war and as a result are traumatized, may also be severely affected by war, although the indirect nature of this impact.

6.2 Rehabilitation and its relation to healthy social ecologies

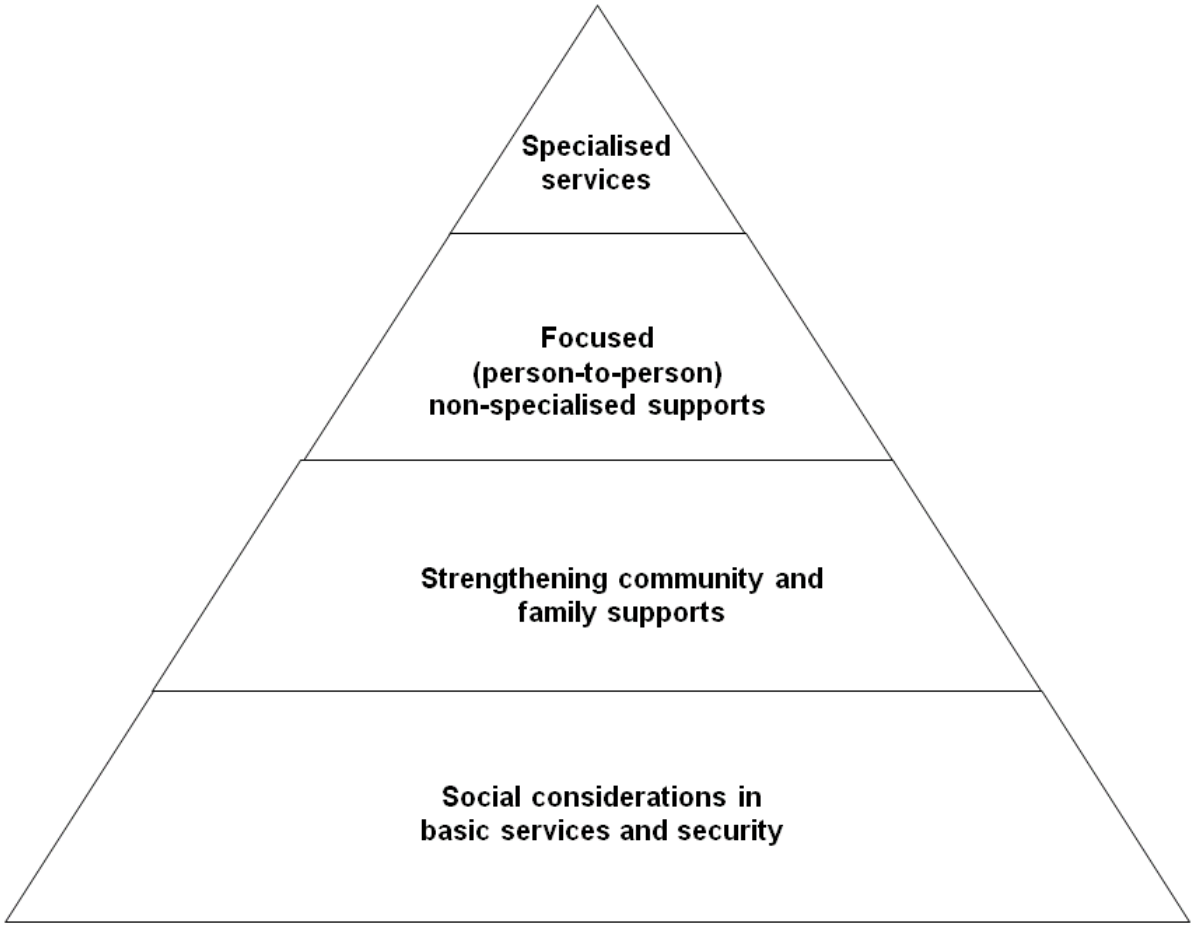
"An incident is in itself not traumatizing, rather it is the *experience* of an incident that involves a traumatization" (Godani et al., 2008, p. 26 – authors' translation). How a child experiences a dramatic event is influenced by a number of factors, and the development and reactions of children affected by war must be understood in relation to the social context in which it occurs (e.g., Bateson, 2000). As noted by Boyden and Mann, "(…) the psychosocial outcome of exposure to adversity […] is mediated by an array of personal, family, and broader environmental factors or processes that interact with each other in a dynamic manner. These processes produce either a heightened probability of negative outcome in children's development and well-being or prevent, or reduce, risk" (2005, p.17-18). Therefore, it all comes down to what resources are available at the different socio-ecological levels; poor outcomes are likely if the resources are compromised while more positive outcomes are possible if the resources are robust. Robust resources - in the family, among peers, in important institutions like kindergartens and schools, but also in the asylum system - "have the potential to improve children's capacity for resilience and to mitigate the effects of conflict experiences" (Betancourt et al. 2013: 71). Studies from Scandinavia also back up the need to focus on a broad spectre of psychosocial aspects when aiming at the rehabilitation and social re/integration of asylum-seeking children. As studies from Sweden by Ascher and Mellander (2010), based on asylum-seeking children's experiences, find that parents, school, friends and leisure time emerged as the most important health-promoting factors. Negative factors were uncertainty about the future, tight economy, housing facilities of low standard and limited schooling.

Based on his research of Jewish orphans after the Holocaust, Hans Keilson (1979) contends that traumatization develops in phases. Keilson finds that what he calls the third traumatic sequence, which is the period after the direct persecution or traumatic event when the surviving Holocaust children lived in orphanages or with foster parents, is the decisive phase. In a supportive environment, a better processing of the trauma was possible. With continuing stress, the psychological pressure became chronic (Ibid.). Transferring the results of our study, we may contend that the third traumatic sequence for war-affected asylum-seeking children is taking place in exile. Consequently, the living conditions and psychosocial support provided while in exile have a significant impact on the children's and youths' future development and health. This implies a great chance and responsibility for the reception and support of war-affected asylum-seeking children.

Although, not everyone develops long-lasting symptoms of psychological stress when exposed to stressful events, some do. Risk factors include, amongst other factors, initial levels of stress arising from previous stressful experiences, but also the present living circumstances of a person. A child who has grown up in a war zone might have a predisposition to stress because of previous war experiences. There are a number of international studies detecting a far higher amount of psychological distress and trauma among asylum-seeking and refugee

children than among the average population (e.g., Fazel et al. 2005; Fazel & Stein 2002; Gaebel et al. 2006; Hepinstall et al. 2004; Lustig et al. 2004; Oppedal et al. 2011; Schwarz-Nielsen & Elklitt 2009.). There is also research showing that UAMs have a higher risk of developing psychological diseases than youngsters living together with their parents (Bean et al. 2007; Huemer et al. 2009). In addition, the conditions of the asylum system itself can lead to or aggravate psychological distress (Fazel & Stein 2002; Gerlach & Pietrowski 2012; Hallas et al. 2007; Silove et al. 1997; 1998, Staehr et al. 2006, Sultan & O'Sullivan 2001, Steel & Silove 2001).

Consistent with the socio-ecological approach we structured the discussion and recommendations according to the model developed by Interagency Standing Committee (IASC) as presented in their *Guidelines on Mental Health and Psychosocial Support in Emergency Setting* (IASC, 2007):



We start by discussing aspects related to "basic services and security" and "community and family support" (accommodation, education, recreational activities and social support), and continue with an elaboration related to "focused, non-specialised supports" and provision of "specialised services" (psychological screening, psycho-education and therapeutic support). In line with the IASC Guidelines, we stress that measures and interventions need to be provided on all layers simultaneously, as interventions and outcomes of such interventions are connected. Rehabilitation and social re/integration efforts towards asylum-seeking children

who are victims of war must have an equal focus on trauma therapy and therapeutic support and on strengthening and improving the children's social ecologies, as these may be essential protective factors in children's lives. As stressed by the CRC, the rehabilitation and social reintegration "shall take place in an environment which fosters the health, self-respect and dignity of the child" (CRC 1989, Art. 39).

6.3 Accommodation, care and psychosocial well-being

Accommodation undoubtedly impacts on children's psychosocial well-being. Living conditions, relocations from place to place, who they live with or are surrounded by, and how long they must stay in asylum centres or similar residence facilities are all important factors, noted by interviewees. There are many considerations that need to be taken into account when authorities decide how to organize accommodation for asylum seekers. The flow of asylum seekers is not static, but changes from month to month and year to year. Also the backgrounds and particular characteristics (familial situation, gender, nationality/ethnic origin…) of asylum seeker will differ. The downside of differentiation of accommodation facilities which depends on different categories of asylum seekers – families, single men, single women, unaccompanied minors, persons with special needs etc. – is that it allows for less flexibility in the asylum system.

Differentiation is to some extent already taking place, not least with regards to UAMs; unaccompanied minors less than 15 years live in care centres operated by the National Child welfare services while unaccompanied minor asylum seekers above 15 live in UAM-homes or separate and smaller reception centres. The situation is, however, quite different for children seeking asylum together with their parents. Not only do children in families have worse living conditions while waiting for the result of their asylum application, the actual case handling also takes longer compared to unaccompanied minors. While the awareness of the need and vulnerability of UAMs has been strengthened over the last years, it appears that the needs of children in asylum-seeking families have to a much larger extent been *ignored*. There appears to be an implicit assumption, not based on evidence, that as long as asylum-seeking children, also those affected by war, are accompanied by their parents, they will receive the necessary care and support (see below on *Family-focused psychosocial support*). As noted by UNHCR, children coming with their families are often treated as adults:

> Children accompanying their parents or caretakers often undergo the same treatment upon arrival as adults, including living in detention or in inappropriate accommodation facilities. Because of their dependence, their vulnerability and their developmental needs, they suffer the hardship inherent in displacement even more acutely (UNHCR 2000:16).

No particular standards related to privacy or space exist for children in families, while UAMs in many cases will have their private room. In some cases, like for the youths living at Erikslust in Sweden, they also have their own separate bathrooms. We have to remember that many of the asylum-seeking children and young people are in a stressed state of mind, and according to interviews in the case countries many of them have, for instance, sleeping problems or frequent nightmares. Sharing a room with others who also suffer from nightmares

and disrupted sleep patterns may lead to increased sleep disturbance as the child will, on top of his or her own nightmares, be disturbed by those of others. On the other hand, some may feel comforted by having another person (a friend or a family member) close to them at night. These individual variations clearly demand individual solutions.

Lack of privacy may, moreover, increase everyday conflicts amongst residents, which possibly provokes violent behaviour. A recent report on violence in Norwegian asylum centres identifies overcrowding or cramped living conditions and lack of privacy as a trigger of violence, while low density of residents appears to have the opposite effect (Proba samfunnsanalyse 2014). This living situation obviously does not favour a *sense-of-safety* for children (see basic layer of the IASC pyramid), as children in families have to live under circumstances of noise, stress, violence as well as cramped together in family housing facilities for a relatively long time. Accommodation facilities are also linked to that of school performance. Studies from Sweden note that school performance is often connected to the possibility of doing homework after school, and children without their own room spend less time doing homework (Boverket 2006, 2008). Lack of privacy and space can thus also have a major impact on children's ability to gain a successful educational career.

As earlier argued in this report, research underlines the clear negative effect several relocations have on refugee children's mental health and development (e.g., Goosen et al. 2014; Nielsen et al. 2009). There is also research on frequent (unplanned) relocations and children in the Child welfare services that shows similar results, highlighting relocations link to attachment disorders in the children (e.g., Kayed et al. 2015; Vinnerljung & Sallnäs 2008). Goosen and colleagues have recently published the results of a longitudinal analysis conducted in the Netherlands which includes data on more than 8,000 asylum seeking children over a time span of eight years. Their research finds that the risk of mental distress increases with high annual relocations and that particularly vulnerable children, such as those having been exposed to violence and children with a mother diagnosed with depression or PTSD, experience an even larger increase in mental health problems (Goosen et al. 2014: 5). Relocations also involve change of school or kindergarten which often means a disruption of integration and social network. In a 9 year follow-up study in Denmark, Montgomery (2010) found that refugee children that have changed school several times are in greater risk of mental health problems. Asylum-seeking children also often have a history of relocations prior to arrival in Norway. Migration and relocations have developmental consequences: "(…) existing literature indicates that it may be harmful for children to move too much and too often before the age of 18 (…) and that regular relocation is associated with behavioural problems later in life" (Salole 2013: 129, authors' translation). Policies on minimizing relocations of asylum-seeking children are therefore highly relevant in order to prevent psychological distress and facilitate a more rapid social integration.

Staff at asylum centres or UAM-homes is amongst those with the greatest possibility to observe, get to know and build relationships with asylum-seeking children. They may, therefore, be crucial in identifying those children who have been victims of, participated in or witnessed acts of war, and consequently may form a valued opinion on whether any of these children are in need of special care and support (see more below on *Identification and*

assessment of risks and resilience). To conduct such an identification demands particular competencies and knowledge. For instance, it demands a certain level of knowledge about symptoms of war-related trauma as well as traumas related to the flight and the asylum-seeking situation. Knowledge of how mental illness and traumatization in parents may impact on the development and psychosocial well-being of children is also essential. Without this competence at asylum-centres and UAM-homes we risk that children who are suffering due to their war experience are not recognised and supported. The link between lack of competence to spot psychological problems and children not receiving appropriate psychiatric care is emphasized also when it comes to children living in Child welfare institutions (Kayed et al. 2015). This knowledge demand may imply that there is a need to carefully select staff and perhaps even employ professionals such as psychologists, at asylum centres.

It also requires cultural competence, cultural sensitivity and intercultural communication skills. These skills are not only important in order to identify special needs, but are essential in everyday life interactions at the asylum centres. Emotional availability should also be emphasized. Although, there has not been much research on positive mental health outcomes due to caring relationships between war-affected children and staff at facilities caring for such children (Betancourt & Khan 2008), there are, nonetheless, some examples. In the study of Wolff & Fesseha (1998), comparing Eritrean orphans in two institutional care settings; one in which the staff focused on meeting the basic needs of the children while not getting emotionally involved and one where staff developed close relationships with the children and were more actively involved in their lives. The result of the research, as put by Betancourt and Khan, was that there were "(…) significantly lower levels of distress among children in the site where close caring relationships between staff and the children in care were encouraged" (2008:7).

Our own data from interviews with staff at asylum centres and UAM-homes in the case countries show that staff themselves believe that both practical and emotional care matters to children in distress. "The most important is that they are seen and heard" (interview with social worker). Also Eide and colleagues (2014) stress the importance of companionship and emotional availability in professionals responsible for care of unaccompanied refugee minors. The same has also recently been emphasized in an evaluation of the Care Reform of UAMs in Norway (Deloitte 2014). Staffing ratios, and hence enough time, must be taken into account if we are to expect staff at asylum centres to build companionships with war-affected and other asylum-seeking children. Maybe even more crucial is the continuity of staff. This is linked to the value of experience but not least, as argued above in relation to relocations, to avoid even more broken relationships in the child's life. As argued by Montgomery and Linnet, "(…) it is essential, particularly for younger children, that they do not need to deal with a lot of different adults, and that it is the same adults that take care of the child every day" (2012: 65).

A common solution to the practical challenges posed by unaccompanied children, independently of their location, has been to create residential centres or shelters. However, lessons from the Global South point out that these accommodation alternatives have proven "(…) unable to provide an attentive, stimulating, and nurturing environment, which is so important in promoting healthy development" (Duncan & Arntson 2004: 23). The family unit,

the biological family as well as alternative families such as foster and adoption families, is considered the best environment for a child to grow up in, and children tend to fare best when they are an integral part of a family unit (on UAMs and foster homes see e.g., Bates et al. 2014). Some authors argue that, ideally, unaccompanied minors should be cared for in foster families rather than UAM-homes. Some also advocate that foster families should preferably be from the child's own culture. Although, many UAMs, particularly those between 16 and 18 years of age, may prefer a small group home environment there are also those who wish to live with and be integrated into a family. It appears, however, that there is a lack of available foster families and that this group of children are not prioritized in the queue for foster families (see for instance Deloitte 2014). Lack of available foster families was also voiced in interviews conducted in Sweden. The two foster families that participated in interviews there stressed the need for a tailored training for foster parents of UAMs from war affected areas. It should also be emphasized that "Siblings should be kept together in the same placement unless they wish otherwise or it is not in their best interests" (Save the Children & UNHCR: 29).

Recommendation 1: Reduce case processing time for families with children and minimize the number of relocations for children in asylum-seeking families as well as for UAMs. This should include all asylum-seeking children, but particularly those who show signs of distress and psychological problems due to personal traumatic experiences or traumatic experiences and/or high levels of stress in their parents.

Recommendation 2: Provide children in asylum-seeking families living conditions that ensure the child's rehabilitation and a healthy development. All families with children should be ensured decentralised residence facilities in ordinary residential areas. The size of residences must allow some privacy as to ensure that children may be protected from overhearing disturbing adult conversations and provide them with a calm space to do home-work. One bed-room apartments are, consequently, not appropriate.

Recommendation 3: Transfer the responsibility for the care of UAMs between 15 and 18 from UDI to the national Child Welfare Service (BUFETAT) to ensure them equal rights and care as other children in Norway.

Recommendation 4: Increase the pool of foster parents to care for UAMs that wish to be included in a family. Particular efforts should be given to recruit foster parents from different ethnicities and cultures so that the pool of foster families may reflect, to the largest extent possible, the population and the newly arrived unaccompanied children. Training of foster parents of UAM should be tailored to include capacity-building on the particularities of war-affected asylum-seeking minors. Training should be offered by the regional BUFETAT offices in collaboration with RVTS. Siblings should be kept together in the same placement, whether in a foster family or in a UAM-home.

Recommendation 5: Ensure that staff at asylum centres with children have the necessary cultural competence and knowledge about symptoms of trauma related to war, the flight and the asylum-seeking situation and how traumatization in parents may impact on the

development of children. This competence and the fact that they can observe these children on a regular basis may make asylum centre staff better equipped to identify children who suffer from trauma and are in the need of specialised care. Competence on mental health issues will also equip them to perform preventive work.

Recommendation 6: Ensure a staff ratio that allows staff members enough time to get to know the children and youth and to follow-up those in need of special attention. Staff should be encouraged to be emotionally available, to become a significant adult to asylum-seeking children who struggle to deal with the past or the current situation. Measures to ensure continuity of staff at asylum centres should, if needed, also be implemented. The Norwegian authorities should make the quality of care (practical and emotional) of asylum-seekers, particularly children the main criterion for entering into agreements with non-public contractors in the management of asylum centres, not low budgets.

6.4 Schools and kindergartens: arenas for integration and rehabilitation

Regaining lost educational opportunities is of particular psychosocial importance for war-affected children, both in terms of acquiring knowledge and of their socialization and social integration. In addition to imparting community values, promoting justice and respect for human rights, it also offers structure and predictability and thus contributes to a child's feeling of safety and emotional security (Duncan & Arntson 2004: 23). The European Council on Refugees & Exiles (ECRE) considers schooling as:

> (…) an essential part of the integration process of refugee children. By teaching a common language, providing opportunities to achieve a better socioeconomic position in life and preparing pupils to live harmoniously in pluralist societies, schools play a key role not only as centres of knowledge acquisition but also as places of formal and informal preparation of refugee children to live in a new society (ECRE 2002: 22, Art. 103).

A supportive school environment is likely to positively impact on social integration, but also on the mental health of war-affected asylum-seeking children and youth. Schools can provide a structured and safe space where the child may develop skills, social competence, peer friendships, and adult relationships (e.g., Chase et al. 2008; Fazel & Stein 2002). Good integration in local schools and establishing a new social network are found to result in less mental health problems (Montgomery 2008), and schools are seen as an ideal place to develop resilience in asylum-seeking children (Fazel & Stein 2002). A supporting school environment can thus be a strong protective factor for future psychosocial development (Socialstyrelsen 2013a: 50). Similarly, kindergartens have the opportunity to provide a stable environment for asylum-seeking children and teach small children the native language (Bagge et al. 2006). We also need to be aware, as argued in the expert interview with Godani, that an early separation may be scary for the child and the parents. Entry into kindergarten should happen when both parents and child are comfortable with the separation.

Education provided to asylum-seeking children should acknowledge that these children may have difficulty concentrating and learning, due to the psychological consequences of war and migration experiences (Osofsky 1995). There are today a myriad of different pedagogical approaches employed in schools and kindergartens. What this study finds is that most interviewees, both experts and practitioners, stress that a pedagogical approach with a clear and predictable structure is more beneficial than approaches with a looser structure. Godani goes as far as calling for a return to blackboard teaching as this, in most cases, will be something familiar and hence stress reducing to asylum-seeking children having experienced war and conflict. The STROF model, highlighted as a good practice by the Danish Red Cross, is also highlighted as a fruitful approach which installs a sense of security and predictability, and hence a sense of re-gaining control.

An important question here is which approach we should use in order to provide a supportive school environment for war-affected asylum-seeking children: Should they be integrated in ordinary classes from the beginning or should they start learning in reception or introduction classes with specialised teachers? OECD is sceptical to inception or reception classes, and recommends the integration of children into regular classes almost from the very beginning (Public Policy and Management Institute 2013). Similarly the Swedish Association of Local Authorities and Regions (2010) highlights a rapid integration of asylum-seeking children as good practices in the education of newly arrived migrant children. According to the OECD, linguistic support should be provided within the mainstream system (Public Policy and Management Institute 2013: 73). The main argument is that asylum-seeking or other migrant children in segregated schools have fewer incentives and fewer opportunities to rapidly learn the native language of the exile country. Psychological arguments for a rapid integration into regular classes are also put forward in several interviews, not least the psychological advantage of spending time with non-traumatized children in a 'normal' setting outside the centre.

At the same time, specialised and segregated schools may be the most advanced in implementing targeted measures for immigrant students. This can be seen in Denmark where personnel at the Red Cross schools and kindergartens have a long and solid experience with regards to education of asylum-seeking children. The methods and pedagogical framework used in the Red Cross schools and kindergartens, as well as in the general reception of these children and youths, are specifically targeting asylum-seeking and refugee children. Moreover, they collaborate well with parents and staff at the asylum centres. They are familiar with how the asylum system works, and the particular challenges related to traumas and everyday stressors in the lives of these children. Their eyes are likely to be better trained to spot those who have difficulties coping with their past experiences and uncertain current situation. They are also likely to have developed a thorough intercultural competence which contributes to a better communication with children and parents.

Another possibility is to have reception classes in ordinary schools. In this case, there is less chance that asylum-seeking children are segregated from other children. This depends, however, as shown in the Swedish case, strongly on the relations between children in reception classes and in the ordinary classes, and also on the number of refugee/ asylum-

seeking children compared to native children attending the school. Aspervika school in Norway is an example where asylum-seeking children are received in reception classes by teachers and employees having long experience enabling a school environment with cultural sensitiveness and an awareness of the impact of traumatizing experiences. The reception class enters, accompanied by their teacher, into ordinary classes in subjects such as arts and crafts, swimming and music. In addition the school helps children to integrate into regular classes and the society where they move when they receive a residence permit. They follow the children on visits to the school, help create relations to classmates and participation in recreational activities.

With society becoming more and more multicultural and diverse, the whole educational system must adapt to the new situation. A multicultural classroom also implies that teacher's training curriculum need to be adapted to increasingly diverse needs of the pupils (ECRE 2002: 22). It should be ensured that schools have sufficient and appropriate resources and tools to facilitate learning for migrant children. The measure of intercultural mediators to facilitate the integration of newly arrived children to the educational system, as implemented in Luxembourg, have apparent benefits also when it comes to communication and interpretation. However, if the school (and kindergarten) should be able to live up to their potential arena for support of war-affected children, targeted resources need to be poured into the school system. The teachers' education and the corresponding curriculum as well as capacity building of in-service teachers should include topics on children, war and trauma. A better understanding of why some children may behave in particular ways is crucial in order to effectively address these children. With such knowledge, professionals in the educational sector are empowered to play a more active role in the identification of war-affected asylum-seeking children that need to be referred to specialist care. Several interviewees, both experts and practitioners, voiced a fear that war-affected children would get a wrong diagnosis, for instance a diagnosis of ADHD (Attention Deficit Hyperactivity Disorder), because professionals, both in schools, kindergartens and within the health sector, are unfamiliar with children's reactions to war-related experiences.

Recommendation 7: Ensure asylum-seeking children the right and access to free kindergarten. We recommend inclusion of asylum-seeking children in ordinary kindergartens as this enhances social integration (making native friends and learning the national language) and may also positively impact on their psychosocial well-being and health through the use of appropriate pedagogical approaches like STROF and Joyful Play (see *Good practices on Education*), methods which have proven to have a positive effect on traumatized children. Staff at kindergartens (at least a portion of pre-school teachers) must undertake competence building on how to care and support traumatized asylum and refugee children, as well as training in methods like STROF and Joyful Play.

Recommendation 8: Ensure, to the extent possible, rapid integration of asylum-seeking children into ordinary schools and regular classes (as also recommended by the OECD). Employing intercultural mediators to facilitate a smooth integration process should be considered. Parallel to the integration into ordinary schools teachers should be offered cross-cultural training and competence building on the impacts experiences of war, armed conflict,

relocation and flight, may have on children's behaviour and learning processes. The Regional resource centres for violence, traumatic stress and suicide prevention (RVTS) should be involved in such training.

Recommendation 9: The School Health Services at the municipal level must be strengthened as its personnel may play a crucial role in attending to the needs of war-affected asylum-seeking children or refer them to other specialist services. It should have an interdisciplinary approach and include a social curator/worker and a psychologist in addition to the school nurse to better be able to attend to the psychosocial needs of war-affected asylum-seeking children. Here Norway should look to Sweden where the School health services includes an interdisciplinary team of a school nurse, a school doctor, a school curator, a school psychologist as well as a special educator (*spesialpedagog*), while the School health services in Norway most commonly consists of only a school nurse. Due to its presence at schools and because *all children* are called in for check-ups, the School Health Service constitutes a health service arena which is likely to be more accessible and less "scary" to the children.

6.5 Participation in recreational activities

It is widely recognized by interviewees, both experts, practitioners, parents and minors, that recreational activities have a positive influence on children's everyday life during the asylum process. Not only is it important for their physical health, but also for their psychological well-being. Gross (2007: 14) argued that physical play might allow children to process traumatic experiences, feel safe and powerful, and build trusting and caring friendships. Research and practice from the Global South also highlights the importance of recreational activities for children in conflict or post-conflict settings. Participation in play, dance, sports, choirs, to mention some, may provide children with moments of relaxation, and may therefore have a healing effect (Kalksma-van Lith et al. 2007). Interviewees in the case countries consider participation in recreational activities as a good manner to reducing conflict levels at the asylum centres and UAM-homes. This is confirmed in the earlier mentioned report on violence at asylum centres in Norway, where activities are frequently mentioned as having a positive impact in the prevention of violence and threats (Proba samfunnsanalyse 2014: 42).

Recreational activities that take place outside the asylum centres give the extra advantage of also facilitating social integration. To be part of a football club or a choir in the community opens up the possibility to make friends outside the centre. It thus expands the social network of the child or young person as well as increasing his or her chance of learning the native language and becoming familiar with the new society. One should, moreover, not ignore the positive impact it may have for an asylum-seeking child to spend time with children in more *normal* life situations (creating a sense of normalcy).

Currently, there is still quite a huge variation in how asylum centres in Norway facilitate and organize recreational activities for their residents (Proba samfunnsanalyse 2014: 42). Some centres cover the membership fee for their children and young people, while others do not (Ibid.: 43). Civil society organizations are often involved in the organization of activities for children living at asylum centres. Such engagements are important and commendable.

However, to depend on civil society organizations in this matter will contribute to large variations between centres, not to universality. Further, since many NGOs have difficulty finding funding for initiatives and projects, the activities might be short-term, causing a lack of predictability and continuity compared to participation in regular recreational activities (a football club, a gym and so on). The Motivational System at Erikslust in Sweden is a good practice in this matter, where staff is actively involved in motivating the UAMs to participate and continue to participate in at least one weekly and regular activity. Importantly, Attendo provides a fixed monthly amount to cover the expenses involved.

Recommendation 10: A standard approach to the rights of asylum-seeking children to recreational activities should be developed and included in the conditions of measures that must be provided by the different operators throughout the country. In other words, we propose a universal approach where all asylum-seeking children, whether accompanied or unaccompanied and independent of where he or she lives, have the same possibility to participate in recreational activities. Operators should consider adopting the principles of the Motivational System (Attendo, Sweden); Encouraging and motivating asylum-seeking children to participate in regular activities outside the asylum centre or UAM-home. A fixed monthly allowance to cover membership fees should be funded by the operator.

Recommendation 11: Take active steps to raise awareness and encourage different entities, private and public organizations as well as municipalities, to activate children in the asylum-seeking phase. The model of Skellefteå in Sweden is a good example of getting the local community engaged. We stress that recreational activities offered by the NGO sector and municipalities should not take place separately but aim at integrating asylum-seeking children with other children in Norway.

6.6 Social support and the importance of supportive adults

Social support and social relationships have a crucial impact on the psychosocial well-being of both children and adults (e.g., Taylor 2009; Mels et al. 2008). House and colleagues (1988: 540) argue that "(…) more socially isolated or less socially integrated individuals are less healthy, psychological and physically." Social support may entail practical help and assistance in the everyday life of asylum-seeking children, but also provision of emotional comfort. The main source of social support for children is most naturally found in their parents. However, asylum-seeking children, particularly those who have been exposed to war, may not have parents who are capable of providing the support the child needs. Moreover, some may have lost one or both parents. Some are seeking asylum alone. UAMs in particular will benefit from having supportive adults in the host country. In their in-depth study of four Sudanese youths with successful experiences of integration in the US, Bates and colleagues (2014) stress the importance of adult relationships in the host country. These adults had the roles of mentors in the new culture, and as the authors note "(…) the most successful youth used relationships with supportive older adults some 10 years after their arrival" (Bates et al. 2014: 189).

Unaccompanied minors are seeking asylum alone, without having any adult caregiver to rely on, and can be assumed to have a particular need for social support provided by adults in the host country. All UAMs in Norway are appointed a representative (previously called a 'guardian') who acts in their parents' stead and looks after their rights in Norway, both legally and financially. Through providing essential practical assistance in the asylum phase, representatives may be in a good position to establish a relationship based on trust that also may provide companionship and social support. However, the current representative scheme does not require nor encourage representatives to take on any social support function.

One measure identified in this project as a good practice is the *support person* measure implemented by the Danish Red Cross. The support person measure is a resource demanding intervention using a bilingual consultant with particular competence spending a couple of hours several days a week with the child and the family. The frequent encounters between the child/family and the support person are crucial for establishing a trusting relationship. The support person measure, thus, involves a supportive adult who knows the new culture and society and may therefore easily assist with practical assistance and information and knowledge about how things function in the new society. This in itself will reduce the child's and his or her family's stress. In addition, the support person enters into a companionship with the child and may become "(…) a conversational partner for the continual reinterpretation of past and present events" (Eide et al. 2014: 128). The fact that the person is bilingual and speaks the child's mother tongue facilitates the conversation and makes it easier for the child to talk about disturbing experiences and emotional pain.

The support person measure should not be mistaken as the same as a support contact person (*støttekontakt*) which is a measure commonly used in the Norwegian Child welfare services. This measure uses laypersons and the aim is mainly social, while the support person measure in the Danish Red Cross is a professional whose task is to support the child and the family not only socially but also psychologically as well as contributing to improving parenting skills. At the same time, the (professional) competence of the support person should reflect the actual needs of the child. The measure of a *primary contact person*, a measure offered to Utøya survivors, is, similarly to the support person measure, identified as a fruitful measure in the psychosocial follow-up of young terror survivors, although this person was not necessarily a professional.

Recommendation 12: Establish the measure of *adult support persons* in the Norwegian asylum system aimed at both unaccompanied and accompanied asylum-seeking children. A support person should particularly be provided to those children who are identified as having psychological problems or who are living with a parent with such problems. The support person should preferably be bilingual, speaking the mother-tongue of the child and Norwegian, know well the Norwegian society and cultural norms and be familiar with how to conduct child-friendly conversations about sensitive issues. The support person measure must be time intensive, involving several visits every week. The support person measure should, when deemed necessary due to the problems of the child, be combined with a therapeutic approach through, for instance, weekly sessions with a music or a drama therapist. For a child who is seeking asylum together with his/her family, the measure should have a family-focus

where other family members also benefit from the support person. Asylum centres must have a budget that allows hiring external professional consultants to implement this support.

Recommendation 13: Consider the possibility of including a social support function into the representative scheme for unaccompanied asylum-seeking minors.

6.7 Identification and assessment of risks and resilience

The identification process of children in need of care is a central element in the setting-up of an adequate support system for war-affected asylum-seeking children with psychological problems. As expressed by one expert interviewee: "They should all do a screening to detect mental problems related to trauma, so that they can be offered proper treatment as soon as possible" (interview with Montgomery). Children may develop a range of different symptoms that may indicate underlying psychological problems, such as different somatic problems (headaches, poor appetite, dizziness,…), sleeping problems, bedwetting, nightmares, concentration problems, isolation, aggressive behaviour, substance use, decreased academic functioning, problems in peer relations, symptoms of anxiety etc., which means that one should not only focus on symptoms of posttraumatic stress disorder when identifying children in need of further psychological support.

Psychological screening of war-affected children is a very complex issue and there is no international agreement on how to approach identification. There is disagreement on how to conduct a screening as well as on when the screening should take place. Some clinicians and psychiatrists argue that if screening in emergency settings is done too early "(…) it would waste resources since it's too early to tell whether the symptoms and limited functionality are normal reactions that will subside with time and layer-1 supports on the IASC pyramid or whether they will develop into or already stem from PTSD."[28] With regards to asylum-seeking children their exposure to war-related traumatic experiences might be several months back in time, but the asylum-seeking period may be experienced as an emergency-like situation where clinical screening should be used in a careful manner. Rather than a clinical screening we suggest that it will be more valuable to conduct a holistic assessment of the psychosocial well-being of asylum-seeking children. Such an assessment must focus both on risks and strengths. Importantly risks should include not only exposure to traumatic events but the wider array of stressors.

We propose an assessment of children's psychosocial well-being based on *a three-step model*: Firstly, increased awareness among personnel involved is a key and can lead to an earlier identification of children who are in need of a more in-depth screening. As argued by Jakobsen et al., "To conduct assessment of asylum seekers in reception centres, there is a need for training and supervision of health professionals who can make systematic calls about mental health" (2007: 76, authors' translation). Secondly, all children living in asylum structures should be offered an in-depth assessment of the psychosocial well-being within two months upon arrival. Such an assessment does not only allow to set-up adequate

[28] Email correspondence with Mike Wessells 15.03.2015.

psychological support for the child, but can also ameliorate the determination of an adequate housing and living environment for this particular child and his or her family. Thirdly, since children sometimes develop psychological problems after a considerable long period of stay in the host country (see e.g., Derluyn et al 2009; Vervliet et al 2013), awareness on the development of psychological problems needs to be there at all times, and it is recommended that the psychosocial well-being assessment is updated regularly throughout the whole asylum-seeking period. Having received a negative outcome of the asylum application is a crucial period for the psychosocial well-being of both adults and children, and rejected families and UAMs should therefore receive particular attention. Rejected asylum-seekers are likely to be at their most vulnerable (while in the asylum system) and would in many cases be more in need of psychological and/or psychiatric care. Children as well as parents may experience re-traumatization faced with the fact that they will have to return to the country in which they first were traumatized. An example of the vulnerability caused by a rejected asylum application came to our attention during the fieldwork in Denmark, where an 11 years old boy had attempted suicide after overhearing his parents' worried conversation regarding the rejection. The boy had witnessed his school being bombed and his friends being killed in the bombing (interview with parents). The thought of going back re-awakened past memories and traumas. The support system around the asylum-seeking child should instead of being reduced be strengthened immediately after the news of a rejected asylum application has been received by the family.

In order to create a holistic assessment of the child, different methods must be used to gather information from a range of different sources. This is highly important, because the child may behave very differently in different settings (school, asylum centre, in the family,…), and the different types of information allows to not only sketching the difficulties and problems the child has, but also his or her strengths, 'healthy' domains of functioning, coping strategies and resilience. The psychosocial well-being assessment needs to include:

- Observations from social workers at the asylum centre, teachers, pre-school teachers, parents, other people involved.
- Interview with the child (in an individual meeting, if needed repeated several times), including also non-verbal methods, such as drawings and toys; hereby large attention needs to be paid to the child's functioning in different life domains and settings (asylum centre, school, family, friends, sports club,…), his or her views on the psychological problems and the way he or she could be supported in this, and his or her strengths and ways of coping. This interview should also provide the child, depending on his or her maturity, specific information about his or her problems, the impact of this process on his or her family's asylum procedure, the possible interventions that can be set up and the impact of these interventions onto his or her own life and that of his family.
- Interview with the child's family members to establish a life-time perspective on the child and the history of the family. As in the interview with the child, this interview should encompass attention to the child's functioning in different life domains and settings (asylum centre, school, family, friends, sports club,…), the way the child could be supported in this, the strengths and ways of coping of both the child and the

family and if possible also the family's views on the psychological problems. It should, however, be kept in mind that "cultural factors have considerable influence on how families are able to share certain issues" and that in some cases families may "obstruct their children from getting treatment and psychiatric evaluations" (Laakso & Karjalainen 2014: 182). This interview should also provide the family specific information about the child's problems, the impact of this process on the family's asylum procedure, the possible interventions that can be set up, and the impact of these interventions onto the life of the child and of the family

- Interview with other significant others in the child's network, such as his or her representative/guardian, social workers or other staff at the reception centre, teachers,…
- Observations from the psychologist during the assessment process.
- If deemed necessary the child should be referred to specialist health services for further diagnostic evaluation and treatment.
- If needed, an in-depth physical diagnostic process needs to be added, in order to exclude underlying somatic problems.
- If needed, an additional screening for possible disabilities needs to be included.

The information from these different sources and persons needs to be brought together in order to draw a holistic picture of the child and his or her functioning, including the child's mental health. If possible, this could be done in a meeting in presence of the main persons, including the child's parents or guardian and the child him/herself. Throughout this assessment process, the following points need to be taken into account: Psychological problems and symptoms, and their explanatory frameworks, are known to be different in people from different *cultures or backgrounds*. Large attention needs to be paid to talk with children and parents on how they interpret particular symptoms, and the explanatory frameworks behind these symptoms. This can help to frame the particular expression of psychological problems and their interpretation in a much more appropriate way. This cross-cultural approach is being practiced in the *Eng Bréck no baussen* project in Luxembourg. In this process, it is also very helpful to simultaneously ask for possible ways of coping with these problems, with which these children and families are familiar to from their own living situation and backgrounds. This might help to develop services that are more connected to children's own background and framework. This means that this process does not only encompass the diagnostic of psychological problems and its underlying causes, but also already a possible way of going forward and setting up specific interventions. Secondly, *language barriers* need to be addressed through using a professional interpreter, skilled in mental health, as much as possible. Thirdly, throughout the assessment process, including the setting up of possible interventions, one needs to take into account the *developmental stage* of the particular child, rather than the child's biological age, since there can be huge differences between the two. Fourth, in addition to the assessment of the child's psychosocial well-being, it could be necessary to also introduce a psychological evaluation of one or both parents, given that the mental health status of the parents might also largely impact the child's psychological wellbeing, and that therefore extra support for the parent(s) and/or family therapy might be needed to address both the child and the parent's psychological wellbeing.

Importantly, "each developmental age provides children unique protecting resources, on one hand, and makes them vulnerable, on the other" (Punamäki 2002: 181). Age must therefore be taken into account when conducting the assessment of risk and resilience of war-affected asylum-seeking children. As younger children have less cognitive competence than older children in making sense of stressors in their environment, they may be particularly vulnerable. The persons involved in the assessment must have good knowledge of child development, also early child development, and age related trauma expressions and symptoms must be considered (see e.g., Punamäki 2002: 184). PTSD symptoms are, for instance, often different in toddlers and preschool children than in school children and adolescences, such as clinging to parents and general anxiety. Thabet and colleagues, in their study of pre-school children in the Gaza Strip, found that this age group responded to war through increased nonspecific behavioural problems like "increased frequency of temper tantrums, fears, overactivity, attentionseeking and poor concentration", while older children more often suffer from post-traumatic stress and depression (Thabet et al. 2006: 157). Pre-school children may also show more regressive, antisocial, aggressive and destructive behaviour (Yule 2000). As revealed by a follow-up study among Bosnian children, aggression in adolescents, evidently due to difficulties in emotional regulation and impulse control, may also be an impact of severe war trauma in preschool age (Kerestes, 2006).

The public Health clinics (Helsestasjonene) are a statutory service and low threshold health service for all children from 0 to 5 years. Through the provision of vaccinations and regular health check-ups of infants and toddlers, these Health clinics constitute an easily accessible health services. Health clinics are an important structure where traumatization or other psychological problems in children or in their parents may be identified.

Finally, we would like underline that it is ethically problematic to identify psychological needs without having in place a system that may provide the necessary care and interventions. The execution of the following recommendations on assessment of the psychosocial well-being of asylum-seeking children requires that recommendations on family-focused psychosocial support and therapeutic treatment of children (see below) are first attended to.

Recommendation 14: To ensure a swift recognition of and response to psychological problems, a cross-culturally sensitive psychological support program should be established at transit centres in Norway. The *Eng Bréck no baussen* program at the first reception centre in Luxembourg may serve as a model of implementation. The program must involve having a psychologist present at the centre who may attend swiftly to psychological needs. The response to the needs of war-affected asylum-seeking children should have a multilevel approach, involving individual, family and group level interventions as well as social integration measures.

Recommendation 15: Ensure an in-depth assessment of the psychosocial well-being of all asylum-seeking children within two months of arrival. Following recommendation 14, this assessment should be conducted by a psychologist at the transit centres, while also involving observations of the children by other staff members at the centre and in schools and kindergartens. The result of the psychosocial well-being assessment should be taken into

account by the UDI when deciding in which asylum centre or UAM-home to place the child, as it needs to be ensured that the necessary therapeutic treatment as well as other support measures are available. The assessment must be updated regularly throughout the asylum-seeking period.

Recommendation 16: A child-friendly and culturally sensitive interview guide to be used in assessment of asylum-seeking children's psychosocial well-being should be developed. The assessment must seek to identify the strengths and resilience of the child as well as protective factors in his/her surroundings, both types of information being important for how to proceed with regards to rehabilitation and social re/integration measures and interventions. The assessment should ensure the involvement of the child and other main actors in the child's network. Conversations with the child as well as with the parents should also seek to reveal culturally appropriate approaches to healing and recovery.

Recommendation 17: Guidelines on how to conduct quality observations of the psychosocial well-being of asylum-seeking children should be developed and information gathered through observations should form part of the assessment procedure. Staff at transit centres, asylum centres, UAM-homes, schools and kindergartens and representatives (guardians) should be trained on the use of these guidelines. The RVTS should be involved in both the development of and training on these guidelines.

Recommendation 18: Conversations with the child and his/her parents should seek to reveal whether the child has been associated with an armed group or military unit, and if in these circumstances they have become victims or perpetrators of acts of violence. Due to their experiences, former child soldiers might be severely traumatized and be in need of a particular attention and support in order to rehabilitate. These conversations must be carried out in a very sensitive manner, as focusing on these topics might be connected with feelings of shame, guilt and taboo for the children and youth affected, which might impede the thematization. Similarly to the result of the assessment of the psychosocial well-being, information on participation in armed conflict should be taken into account by the UDI when deciding where the child should live while waiting for the result of their asylum case, as specialised health care might be necessary.

Recommendation 19: Health personnel in Health clinics should have the knowledge and expertise needed to identify symptoms of traumatization or other psychological problems of asylum-seeking children and parents. The clinics' personnel must be ensured capacity building on how to recognise symptoms of war-related trauma, particularly trauma symptoms in infants and toddlers. It is further recommended to establish an interagency cooperation with primary and specialist health care services so that these children and their families receive necessary and appropriate health care.

6.8 Family-focused psychosocial support

As this report has shown, a child's well-being (as well as his or her resilience and coping strategies) is affected by past and current experiences and the social support available in the social ecologies of family and community (e.g., Kostelny 2006; Wessells 1998; see also

Ingvarsdotter 2012). In contexts of war and conflict "(…) systems that are normally sources of support and protection, such as the family, [may] become sources of risk and developmental damage" (Boothby et al. 2006: 5). This is particularly the case if parents are traumatized. How war-affected children cope is therefore also dependent on parents' exposure and coping with war traumas (Montgomery & Linnet 2012; Godani et al. 2008). Normally a child would turn to his or her parents for comfort and support, but when the parents are traumatized they are often pre-occupied with their own problems and less sensitive and able to meet the needs of the child.

In other words, they may be emotionally and functionally unavailable to their child which has a clear negative impact on the child's psychosocial well-being. Research from Sweden shows that 87 % of children with traumatized parents show disorganised attachment - "(…) caught between a desire for nearness and a fear of approaching the parent" (Daud 2008: 8). Recent research also stresses the risk that parents may 'transmit' their unprocessed traumas to their children (Daud 2008; van Ee 2013; Brendler-Lindqvist 2014). In addition, the risk of family violence is likely to increase in families where one or both parents are traumatized or suffering from other forms of psychological problems (interview with Montgomery). This close link between the psychosocial well-being of the child and the parents' mental health demands family-focused interventions which, if needed, include psychological support for the child's caregivers. Basically, we cannot ensure the realization of the child's right to rehabilitation without extending the right to treatment and support to their parents. As argued by Ascher and Hjern, re-creating the asylum-seeking child's feeling of hope and security is central and can partly be done through re-creating hope and security of the parents (Ascher & Hjern 2014: 115).

A family-focused approach to war-affected asylum-seeking children, focuses, as we have seen in the good practice of the Danish Red Cross, both on the individual child's well-being and on strengthening parents and building parental skills. It is of great importance to enable parents to feel more confident in their parenting role, in relation to children that are traumatized by armed conflict but also in relation to parenting in a new cultural setting. The family-focused psychosocial support should, in addition to attending to the individual child's and parent's psychological needs, also attend to the collective needs of the family, such as reducing daily stress in the family and address urgent practical problems. Many asylum-seeking parents as well as children and youth are unfamiliar with and sceptical to western approaches to psychological problems (they may not even call them such). To start immediately with treatment may therefore be impossible. As maintained by Ehntholt & Yule (2006), the phase of model to intervention of war-affected refugee children is normally a phase of establishing trust and safety. Practical issues and daily stressors in the life of a 'traumatized family' must be attended to and through these interactions trust may be built. Again we would like to stress the importance of the *support person measure* in Denmark (see more above). Similarly to the implementation in the Danish Red Cross, it is psychosocial problems identified in the child that should lead to the provision of a support person, but the support offered by this person must also address challenges and needs in the family as a whole, not least challenges linked to parenting.

A comprehensive family-focused approach requires, most likely, an interdisciplinary approach where several welfare services and professionals collaborate. The recently established Transcultural centre in Stavanger seems to be a good example of such an approach, as is the Danish Red Cross' collaboration with the interdisciplinary staff at Solvita. Parents who suffer from traumatization and other mental health problems must be ensured the necessary psychological and psychiatric help. Improved mental health of parents will evidently make them better able to support and care for their own children.

Recommendation 20: Ensure a family-focused approach to psychosocial support (for instance *the adult support person* measure, see Recommendation 12) helping parents to cope with their own problems, support parents on how to minimize that their own mental stress and traumas affect their children, and help them understand how to handle the war-trauma reactions of their children. Competent professionals, preferably bi-lingual, should be used in this kind of interventions. Asylum centres must have a budget that allows hiring external professional consultants to implement this support.

Recommendation 21: Offer appropriate psychological and psychiatric treatment to asylum-seeking adults. If necessary, adults with children should be prioritized. The right to psychiatric treatment must be extended to adults who have had their asylum application rejected. Adult psychiatric health services (regional) must be strengthened to be able to provide the necessary, rapid and appropriate psychological and psychiatric treatment to asylum-seeking adults affected by war. A close collaboration with other health services, particularly BUP, is crucial to succeed in improving the health situation in asylum-seeking families.

6.9 Therapeutic treatment for children

The classic trauma therapeutic approach states that before confronting traumatic experiences in a therapeutic context, the client must first have achieved a secure and stable situation. Otherwise the confrontation with the event might lead to overwhelming emotions and a loss of control, which is not a healing, but rather a re-traumatizing experience (Huber 2009). Therefore, some practitioners interviewed for this research argued that working on trauma should be considered cautiously for children who are still in an insecure living situation, such as asylum-seeking children.

Although in most cases, an explicit confrontation with traumatic material at an early stage of the stay in exile might neither be recommendable nor wanted by the affected persons, this does not mean that trauma therapy should not be available for war-affected children in first reception centres or in further stages of the asylum reception system. A child might suffer from severe traumatic symptoms, such as flashbacks, nightmares, symptoms of depression, etc. Although a child is not yet in a stable situation, these symptoms should not be ignored, also because they might probably aggravate or become chronic when a child is not given appropriate care. So it is necessary to at least offer children access to trauma-therapeutic stabilization. As mentioned earlier, the probability that they have gone through traumatic experiences and that they develop symptoms of psychological distress is significantly higher

among war-affected refugee and asylum-seeking children than among the average non-migrant population. An early starting of the stabilizing part of the trauma therapy also has the advantage that the time before a child or a family achieves a secure residence status is being used in a fruitful way. As soon as a stable situation is achieved, the processing of the trauma can start to happen (Zito 2010). It should, however, be underlined that similarly to the debate on psychological screening there is no such thing as professional agreement on whether or not trauma processing is a fruitful approach. Also nationally there are divergent opinions; NKVTS and RVTS are generally in favour of this type of trauma therapy, while the Transcultural Centre in Stavanger is much more sceptical to trauma therapy while the person is awaiting the result of the asylum application and of the opinion that such treatment may cause re-traumatization in the patient.

Trauma therapy generally consists of different phases: first – and most important – the stabilization, when a person learns how to deal with the symptoms, how to regain control over emotional reactions. At the same time, social stability needs to be achieved as a basis for psychic stability. Only if a traumatized person has built up inner and outer stability, the confrontation with (or working through) the traumatic memories in therapy are recommended. This therapeutic confrontation makes sense, because traumatic reactions can be *triggered* whenever a traumatized person in his/her everyday-life is confronted with a stimulus resembling the traumatic experience (e.g., a sound, a smell etc.). By systematically working on all aspects of the experience in therapy, it can be *processed* and turned into a memory of something painful that happened in the past, instead of something still overwhelming in the present. However, some scholars argue that confrontation with and processing of the trauma is not always helpful (Huber 2009; Hanswille & Kissenbeck 2008). The approach towards trauma therapy that is used therefore needs to be considered very cautiously, preferably together with the child and/or with his/her family, and taking account of their past experiences and ways of coping herein. One should consider a range of methods in trauma therapy, such as verbal and non-verbal therapeutic methods, individual and family therapy, and also group counselling sessions.

There are positive outcomes related to using *narrative conversation group methods* with war-affected asylum-seeking and refugee children (e.g., Myrvoll & Lundesgaard 2012; Jenssen & Myrvoll 2013).[29] There may be different approaches to such group interventions; they may involve creative activities, rituals, story-telling/creation, conversations and teaching on 'normal' reactions to abnormal experiences, emotions, hygiene, relaxation techniques etc. Typical goals of group interventions are emotional control and coping with symptoms and stressors. These types of groups aims to strengthen resilience, prevent and reduce psychological health problems and provide them with tools on how to deal with traumatizing experiences (Myrvoll & Lundesgaard 2012: 241-242, 269). Good practices of narrative groups and psycho-education groups identified in this report includes friRum used in Denmark and conversation groups organized in Sandnes where asylum-seeking children and youth meet to talk, reflect and discuss. In addition to a potential therapeutic effect, these

[29] These types of group interventions are beneficial for *all* asylum-seeking children, not only those affected by war.

groups may also have the function of peer support groups. McKay and colleagues conclude that group conversations among young women formerly associated with fighting forces and armed groups in Sierra Leone stimulated "empathy and care" among participants and thus "non-formal psychosocial support" to those involved (McKay et al. 2010: 62).

Group interventions may be organized in the asylum centres or UAM-homes but as all children go to schools, schools may be in a particular good position to implement such interventions. In general, school-based interventions are often highlighted as an effective approach (e.g. Betancourt et al. 2013). As seen in the case of Danish Red Cross' friRum project, the barrier to participating is lowered and regular attendance is assumed to be easier achieved when such group interventions are organized in the school setting. The groups should, nevertheless, be facilitated by a psychologist in close collaboration with a teacher. If organized at schools, teachers who participate in implementing group interventions should be given additional training on children and mental health issues.

Narrative conversation group approaches is beneficial to older children who are able to express themselves through speech. Interventions with traumatized pre-school children, on the other hand, must be adapted to their cognitive development and rather involve playing, drawing and other symbolic activities. The method of Joyful Play serves as a good example of group activities for pre-school children.

Interviews in Denmark, Sweden and Luxembourg reveal that individual trauma therapy is rarely offered to traumatized asylum-seeking children. Therefore the fieldwork did not yield much good practices related to trauma therapy to children affected by war. However, according to reviews of treatment to refugee children with war-related trauma some types of treatment appear to be more promising than others. In their review of treatment for reducing PTSD symptoms in young refugees Ehntholt and Yule (2006) highlight the effectiveness of Cognitive-behavioural treatment (CBT), Testimonial psychotherapy, Narrative exposure therapy and Eye movement desensitisation and reprocessing. Also more recently, Betancourt et al. (2013) stress Trauma-focused CBT, Testimonial psychotherapy and Narrative exposure therapy as good practice methods in individual treatment of war-affected children, with "CBT being the most advocated approach" (Kalantari et al. 2012: 141).

In general, reconstruction of events works well in individual treatment with children (interview with Godani). In such approaches the child is encouraged to reconstruct events through toys, play or drawing and while the therapist facilitates the reconstruction through asking questions like "What were you thinking then?", "How did you feel?" and "What did you do?" The approach aims at helping the child to 'work through' his or her feelings and thoughts related to the traumatic event. We would like to underline that treatment methods are constantly evolving and adapted to new situations and new population groups. Also, there is little research on trauma treatment on adult asylum seekers and refugees, and even less on children. "The research that does exist is mostly on children with singular trauma, while asylum and refugee children have multiple traumas or a complex PTSD."[30] There is also lack of systematic knowledge on developmental consequences of migration on children (Salole

[30] Email correspondence with Aina B. Vaage 15.03.2015.

(2013). More research is therefore necessary before more precise and certain recommendations on particular trauma treatment can be made (e.g., Buhmann 2014). Future research must take into consideration culturally appropriate understanding of trauma as well as culturally appropriate coping strategies, which may very well be avoidance rather than confrontation or 'working-through' (e.g., Nordanger 2007).

Interventions and professionals must, moreover, take into account the individual child, his or her age, environment (social ecologies), temperament and personality, attachment styles (the secure child, the insecure-avoidant child, the insecure-ambivalent child and the disorganized child – see e.g., Punamäki 2002: 189-192). In accordance with the resilience thinking the therapist must seek to become familiar with the child's characteristic ways of coping; "Children should not be stripped of their personal ways of responding to trauma, but they can be guided to create new and more repertories strategies" (Ibid.: 194).

To provide appropriate treatment to war-affected asylum-seeking children professionals must have knowledge of how to deal with cross-cultural diagnostic processes, how to work with interpreters as "potential co-therapists" (Ehntholt & Yule 2006: 1206), how to care for people who are in precarious living situations and how to provide treatment of children who have been confronted with violence and fright linked to war and armed conflict.

To have the right to health services is, unfortunately, not equivalent to having *access* to health services. With regards to war-affected asylum-seeking children, this is especially visible in psychological health care provisions, as expressed by Montgomery, the interviewed expert from Denmark: "If there is no one that offers the treatment the child needs, then nobody gets it" (interview with Montgomery). This study on the rehabilitation and social re/integration of war-affected asylum-seeking children did not include an assessment of appropriate competence within different Norwegian health service structures. However, our impression is that there appears to be a lack of competence on treatment of asylum-seeking children with war-related traumas within the general health care services in Norway. This is not particular for the Norwegian society, but is also the situation in the case countries as presented us by interviewees and through reviewing national documents and reports.

Lack of competence, as well as lack of confidence, may cause a situation where war-affected asylum-seeking children are referred from one health structure to another without receiving, or at least delaying, mental health care these children needs. Today, when mental health care cases involving children are perceived as too complex to solve by the municipal health services, these are referred to Child and Adolescent Psychiatric Out-patient Clinic (BUP) which is part of the specialist health services at the regional level. However, also within this specialised health service there appears to be a lack of expertise covering war trauma in children and vulnerability due to the flight and the asylum-seeking situation. There is also a lack of competence on the particularities of unaccompanied asylum-seeking minors (Deloitte 2014). If professionals at BUP do not experience that they have the competence they need to address the complexity of providing therapy to children in an uncertain asylum-seeking situation, this may cause a reluctance to take on the responsibility of these children. A recent report on the care of UAMs who are younger than 15 years of age and seeking asylum in

Norway confirms this impression, stating that it is challenging to get BUP to engage in cases of unaccompanied asylum-seeking minors in need of psychiatric health services (Deloitte 2014: 34) and staff at the care centres experience that "(…) children do not get the care they need from BUP" (Ibid.: 42). Interviewees at BUP in Sweden voice that they do not offer asylum-seeking youth trauma treatment, this because they believe the lives of the UAMs must first be stabilized but also because they do not have expert knowledge on war-related trauma (interview with psychologist and head of department). Some Swedish BUP offices have Asylum Psychiatric Units, where BUP may refer asylum-seeking children in need of more intensive and specialised treatment. However, most often they do not receive trauma therapy before they have gained a residence permit and are settled in a municipality. As this may take months and sometimes even years, a health care system that does not offer early treatment may result in a larger number of children and young people with chronical psychological problems. War-affected asylum-seeking children's right to rehabilitation is independent of their legal status in the host country.

When addressing the question on how to organize rehabilitation services to meet the needs of war-affected asylum-seeking children, most expert and practitioner interviewees draw attention to a situation of not enough specialised competence within the mainstream health system. Montgomery argued:

> If these children need support related to their traumas, they should have the right to specialised help such as they could get at our centre. However, DIGNITY only treats adults who have received a permanent residence permit. For asylum seekers it is the limited budget of the Red Cross that will have to do (interview with Montgomery).

As of today, the most specialised expertise in Norway, combining expertise on child trauma and competence on asylum-seekers and refugees, seems to be centered in the RVTS (regional level) and their *Professional teams on refugee health and forced migration*. A problem, as we see it, is that these centres are only to give guidance and capacity-building to professionals in the mainstream system, not provide treatment. To our knowledge, the Transcultural Centre in Stavanger is currently the only public entity which offers both advisory and competence building and direct treatment of children in the asylum system. While the lack of specialised competence to meet the needs of asylum-seeking children affected by war is still a challenge to realizing their right to rehabilitation, the professional environments *with* this competence must, as we see it, also be involved in direct treatment, not only competence building. At the same time, regional teams will have to cover rather large geographic areas. Long distances will most likely negatively impact on the frequency and regularity of treatment sessions, probably also on equal access to such specialised services. It is therefore crucial that the health services in the municipalities are strengthened to better be able to care for war-affected asylum-seeking children. Refugee health care services, such as the one in Trondheim, consists currently of doctors, nurses, midwives, physiotherapists and psychiatric nurses. These teams may be strengthened through inclusion of child psychologists or child psychiatrists, preferably with competence of and experience with a variety of narrative and creative trauma therapy with children. Capacity building of psychiatric nurses equipping them to attend to the needs of war-affected children should also take place. The School health service is also an important structure, not least because of its accessibility to children. The barrier for an asylum-seeking

child to contact health personnel is likely to be much smaller when such personnel are present in schools.

Recommendation 22: Psycho-education and group interventions such as *friRum* should be organized in asylum centres or in schools with both war-affected and other asylum-seeking children. For children in families, the group intervention should be conducted in close collaboration with parents and include family events where the whole family participates. The groups should be led by a psychologist preferably in collaboration with a teacher with whom the children are already familiar. Such group interventions should be organized through a collaboration between the asylum centres or UAM-homes, schools, municipal Refugee health care services or BUP or potentially also by the involvement of the School health service (see *Recommendation 9*).

Recommendation 23: War-affected (and other) asylum-seeking children in need of trauma therapy or other forms of specialised treatment must be ensured rapid access to treatment. Individual therapeutic approaches may include interventions like Trauma-focused Cognitive-behavioural treatment, Testimonial psychotherapy and Narrative exposure therapy. However, great care must be taken to ensure that children are not re-traumatized due to a too confrontational approach to treatment. Based on the current organization of health care services in Norway, trauma therapy to asylum-seeking children should be provided by BUP. However, to successfully realize this task BUP need more resources (not least with regards to human resources) and more specialised competence on treatment of children with war-related traumas.

Recommendation 24: As it will take time before BUP and the municipal health care structures have the necessary competence and experience, increasing the responsibility of RVTS to also provide treatment of war-affected asylum-seeking children should be considered. Due to the particularities of trauma treatment while in an uncertain asylum situation, it should also be considered to establish specialised mental health services at the municipal level as this will assure better access to treatment than regional structures would. The Transcultural Centre in Stavanger, their interdisciplinary approach and providing both advisory and competence building and direct treatment could potentially be a prototype of such specialised centres.

Recommendation 25: Municipal Refugee health care services (or teams) should be present in every municipality and should employ a *proactive approach* (similar to the one put in place in the aftermath of the Utøya attack) to ensure that those children and families who are not capable of seeking help themselves also should be approached and offered psychosocial assistance.

Recommendation 26: Healthcare providers working with traumatized children may suffer from compassion fatigue or secondary traumatic stress. A system of follow-up and de-briefing of health personnel working directly with traumatized children should be put in place.

6.10Long-term competence plan

With society becoming more and more multicultural and divers, the educational system as well as health services must adapt to the new situation. These adaptations must not only take place in schools and health care structures but also in higher education institutions in which professionals and personnel are trained and educated. Curriculums at these higher education institutions must to be altered to more fully encompass the increasingly diverse needs and social and cultural background of the population.

Recommendation 27: The impact of war and armed conflict on children's psychosocial well-being and development should become key themes in the long-term competence plan of professionals such as health personnel and teachers and preschool teachers. The education of these professionals must encompass culturally appropriate approaches to learning, psycho-education and mental health care of children suffering from war-related traumas.

7 Concluding remarks

A policy that aims at realizing the right to rehabilitation and social reintegration of asylum-seeking children who have been affected by war must have a holistic approach, consistent with social-ecological framework of child development (Bronfenbrenner 1979; see also Fernando & Ferrari 2013). Rehabilitation interventions and social re/integration measures need to take into account both protective factors and risk factors. Interventions should seek to strengthen the former and reduce the latter. Exposure to war and violence is the number one risk factor. Many of the asylum-seeking children bring with them multiple exposures to traumatic experiences. Besides this risk factor the study identifies risk factors inherent in the current asylum and support system, not least linked to cramped living conditions, relocations and broken relationships, living with traumatized parents, an uncertain and stressful everyday situation, obstacles to social integration and lack of competent and confident health personnel and structures to provide appropriate therapeutic care for those children, or those parents, who are traumatized or suffer from other types of mental problems related to war experiences. At the same time, this study also identified protective factors that can play an important role in promoting children's psychosocial wellbeing. Examples of protective factors are, for instance, structured activities within arenas such as school and kindergarten, a well-established and stable accommodation, but also participation in regular recreational activities, supportive and emotionally available parents, supportive adults outside the family and peer relationships, not least through establishing new social networks with native peers.

As noted by Hjern & Jeppsson, "Immigrant and refugee policy is usually made with adult refugees in mind, and the fact that some 25-30 % of the populations are children is usually forgotten" (2005: 125). Neither has the immigration policy taken into consideration that many of the asylum-seeking children have been victims of, have participated in or have witnessed acts of war in their countries of origin. The realization of war-affected asylum-seeking children's right to rehabilitation and social reintegration, as required by the Convention of the Rights of the Child, "shall take place in an environment which fosters the health, self-respect and dignity of the child" (CRC 1989, Art. 39). This can only be done through including social systems like the family, schools, the asylum system and the wider community. Research over the last couple of decades has shown that many war-affected children, even former child soldiers, fare better than what we may initially expect. Evidence of resilience is shown in studies both in the Global South (e.g., Betancourt 2013; Vindevogel et al., 2012; Wessells 2006) and in children seeking refuge and asylum in Western countries (e.g., Ascher & Mellander 2010; Eide 2012). The characteristics of these "success stories" are largely linked to social support and assistance to cope with their war experiences, if necessary also specialised trauma treatment.

It is important to increase public and political awareness of children who have been victims of, participated in or witnessed acts of war, and to "(…) understand the impact of such atrocities on mental health and development, and most importantly, to develop programs to curb and

heal the effects of war experiences on children and youth" (Barenbaum et al. 2004: 41). There is extensive research evidence supporting a social ecological approach to improve psychosocial well-being of war-affected children (e.g., Fernando & Ferrari 2013; Betancourt et al. 2008; Boothby et al. 2006; Ungar 2005). However, as noted earlier, evidence-based research on the effectiveness of measures and interventions aiming at rehabilitation and integration war-affected children seeking asylum in the Western world is scarce. It is of utmost importance that such research follows in the footsteps of the implementation interventions, including both short-term and long-term effects. Another major issue is the lack of cultural and trauma-related competence in mainstream services, be it educational institutions, the Child welfare services and health care services. As the mainstream services are the cornerstone of service delivery there needs to be a greater investment in improving their capacity to meet their responsibilities with regards to war-affected asylum-seeking children. Also personnel at asylum centres and UAM-homes must receive training in order to recognise children who need special care. Without increased capacity and competence in the mainstream services, war-affected children's right to rehabilitation and social re/integration is much less likely to be realized.

Protracted war and armed conflict in countries like Syria, South Sudan, the Central African Republic, the Democratic Republic of Congo and Iraq, amongst others, may lead to increased numbers of asylum seekers, including children, who arrive in exile countries carrying with them traumatic experiences. Some children may be able to cope and heal with social support, but for others war and armed conflict may potentially have life-long consequences if they don't receive specialized health care. This situation stresses the *urgency* of putting in place a solid support system to assist these children and to realize their right to rehabilitation and social integration. It is, consequently, our social obligation to provide them with the care and support they need in order to heal.

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List of interviewees

National and international experts

- René Schlechter, president of the Ombuds Committee and Ombudsman for Children's rights, Luxembourg, 28.08.2014
- Edith Montgomery, PhD, DMSc, Senior researcher at DIGNITY - Danish Institute Against Torture, Denmark, 29.09.2014
- Monica Brendler-Lindqvist, Director of the Red cross Centre for Torture Victims in Stockholm, Sweden, 01.10.2014
- Guhn Godani, psychologist and psycho-therapist, Kris- och traumacentrum in Stockholm, Sweden, 02.10.2014
- Aina Basilier Vaage, Child psychiatrist, Transcultural centre in Stavanger, Norway, 04.11.2014.

Practitioners

Luxembourg:

- Psychologist (Foyer Don Bosco, Red Cross), (29.08.2014)
- Educator (Foyer Don Bosco, Red Cross), (29.08.2014)

Denmark:

- Child psychologist and child psychiatrist (group interview) (Red Cross Child Unit), 29.09.2014
- The project leader of friRum – (Red Cross head office), 29.09.2014
- Social worker (Vipperød Centre, Red Cross), 30.09.2014
- Social curator (Avnstrup Centre, Red Cross), 01.10.2014
- Preschool teacher (Avnstrup Centre, Red Cross), 01.10.2014

Sweden:

- Nurse (Fittja vårdcentral), 02.10.2014
- Psychologist and Head of Department (group interview) (BUP-mottagningen Farsta), 03.10.2014
- Two staff members [behandlingsassistenter] (Erikslust PUT Camp, Attendo), 16.10.-17.10.2014

Norway:

- Two nurses (Helsetjenester for asylsøkere og flyktninger, Sandnes), 04.11.2014.
- Social worker (Aspervika skole, Sandnes), 06.11.2014.

War-affected children and parents

- Two unaccompanied minors (Vipperød Centre, Denmark), 30.09.2014
- Two mothers and two fathers (Avnstrup Centre, Denmark), 01.10.2014
- Two unaccompanied minors (Erikslust PUT Camp, Sweden), 16.10.2014
- One mother and one minor daughter (Röstånga ABB, Sweden), 17.10.2014

Foster parents

- Two foster mothers and one foster father (linked to Erikslust PUT Camp, Sweden), 16.10.2014 and 17.10.2014

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