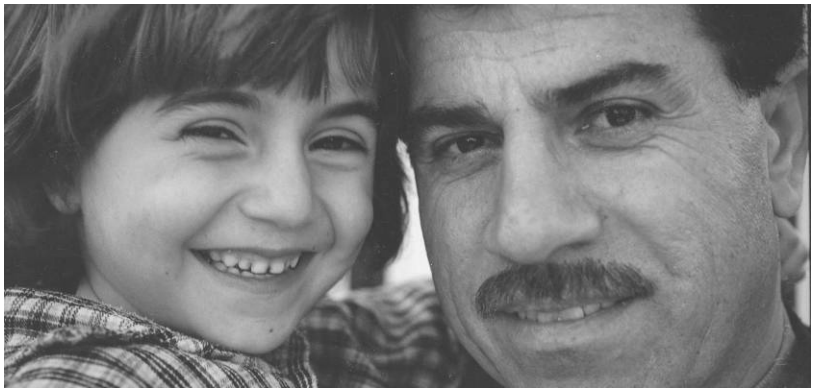
Reception of asylum seeking and refugee children in the Nordic countries: The Danish report



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Reception of asylum seeking and refugee children in the Nordic countries: The Danish report (2010)

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Photo by Willy Hansen

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Reception of asylum seeking and refugee children in Denmark 2002-2010

Introduction

This report is made in answer to a questionnaire developed by The Nordic Network for Research on Refugee Children attached to the Nordic School of Public Health (NHV) in Göteborg[1]. Similar reports are available for Norway and Sweden. Answers to the questionnaire rely on a review of relevant web-sites, available literature and interviews with professionals of different disciplines who worked many years in this field. (Acknowledgements see p. 50)

Some structural changes were made to adapt the questionnaire to the Danish contexts. There are 9 chapters, one more than the original questionnaire due to an additional chapter about illegal persons. We have clustered questions according to similar themes, for ex. chapter 1 regroups all questions about statistics; chapter 2 includes all questions about legal phases of asylum, while chapter 3 regroups questions about national bodies and guidelines. For the sake of analysis we made also some changes in the order of questions in the chapters.

We have expanded questions regarding medical examinations to cover psychological and psychiatric assessment and treatment. Furthermore, we have added questions about for ex. request of interpreters, changes we find relevant for the purpose of this questionnaire.

The themes the questionnaire poses are answered by using two perspectives: (a) children during their asylum period and (b) children during their integration period.

Most questions are answered, though we regret there are statistical data missing which it has not been possible to get from the Danish authorities.

To some answers we added “additional information” for you to get a better view of the developments in Denmark in the last years.

You can easily find the numbers corresponding to literature references as well as cross references in the text.

[1] www.nordicrefugeechlildren.se

1. Statistics about asylum seekers and refugees

Total children to immigrants in Denmark 2006-2010 (Appendix 1)

Unaccompanied children 2004-2009 (Appendix 2)

Unaccompanied children's age and gender 2002-2007 (Appendix 3)

Overall statistics of immigration to DK from 2002-2009
(Appendix 4)

Asylum seekers 2002-2009 with countries of origin (Appendix 5)

Missing data

The following information, requested in the questionnaire, cannot be found:

- Age and sex distribution of accompanied children (not registered)
- Number of children who have received permanent or temporary residence, been rejected and expelled or rejected but are unable to go back to their destinations
- Number of these children who were born in DK
- Parent's educational background and age
- Description of the family (nuclear family, single parent family, caregiver (not parent), other)
- Percentage of asylum seeking children who go through health examinations, psychological or psychiatric assessments compared to overall figures of asylum seeking children
- Percentage of refugee children covered by health examinations or psychological assessments during their integration period
- Percentage of referrals of asylum seeking and refugee children to child-psychiatric services

2. Legal phases of asylum

"In Denmark the asylum application process (…) has three phases after registration with the Danish police. The **first phase,** conducted by the Immigration Services (IS), is one of identification and categorization of the applicant as a legitimate asylum seeker." (42 p. 70) In this phase the applicant is interviewed by a policeman with the help of an interpreter. It depends on the applicant to provide the necessary documentation to support his/her asylum application. Children to asylum-seeking families are not individually interviewed during the asylum case process. (42 p. 73) Elder children, who are in their asylum period together with their parents cannot apply independently or be granted legal advice.

The **second phase** involves the authorities gathering available information and evaluating the documentation either for or against granting residence. These two phases last between 8 -12 months. (42 p. 71)

NGO working with asylum seekers report that asylum periods can vary from 3 to 10 months or from 3 to 6 years. Attorneys have experienced cases with extremely long asylum periods up to 10 years.

"While adults are prohibited from engaging in paid work their status in the asylum process may allow them to attend job training." (42 p. 73)

Once the authorities grant asylum according to Danish laws the applicant (and his family) enters the **third phase**, waiting to be allocated in a municipality responsible for housing and of enrolling parents in a three-year "introduction program". Children are introduced to day-care centers or public schools or other educational services.

In case the asylum seeker's application is rejected, **"expulsion phase 3"**, the asylum seeker must leave Denmark or may apply for humanitarian residence permit to the Danish authorities or accept voluntary deportation. Some asylum seekers refuse deportation on grounds their personal security is threatened if they go back to the country they fled from.

Those asylum seekers, who refused to sign a voluntary deportation contract, are subject to "motivation-enhancing measures" such as: compulsory signing-in with the police twice a week, and instead of pocket money these asylum seekers receive a basket of food every week and in some cases they are detained. Asylum seekers who find themselves in this condition have in practice, no legal rights.

Even though asylum seekers do not cooperate with the authorities, they can be deported by force by the police. Yet **forced deportation** requires the receiving country's approval. Lack of bilateral agreements between Denmark and receiving countries or refusal from the authorities to receive the forced deported, hinders forced deportation. In other words, it means that asylum seekers can be subject to "motivation-enhancing measures" for an indefinite time.

A considerable extension of the asylum period in Denmark - **Protracted asylum phase**- was observed since 2002 causing a dead end for asylum seekers whose applications were rejected and either were unable to go back to their destinations or refused to go back to countries which would not protect their human or civil rights. (Appendix 6)

"In 2007 a big controversy developed around groups of asylum seekers from countries without such agreements (e.g. Kosovo, Iraq). Asylum seekers (from these countries) who had been denied residence permits but had not been deported included families (…) living in Danish asylum centres for as long as nine years." (42 p. 71)

This has been the case of families from Somalia, Iran and Iraq. Children to these families are exposed to structural stressors burdening their development and daily life. At a seminar in April 2009 about Children as Asylum Seekers Ph. D. student Signe Smith Nielsen told:

> "*Children seeking asylum constitute one of the most vulnerable groups in society. There is a high prevalence of psychopathology among these children, and much of this can be ascribed to the psycho-social strains that are linked to the migration process, the refugee and immigrant status and the conditions in the often protracted asylum phase. In Denmark, we found that 35% of the 4-16 year old asylum seeking children and 58% of the 11-16 year old children showed evidence of having a psychiatric disorder. Furthermore, we found that asylum seeking children had numerous physical as well as psychological symptoms, poor self-perceived quality of life and a fragile social network. Protracted stay at asylum centers and multiple relocations within the asylum system appeared to have an adverse effect on asylum-seeking children's mental health. It is critical that the asylum systems in Western host countries seek to protect children in accordance with the Convention of the Rights of the Child and other international rights documents."* (33)

From this study we learn that children are especially affected when their families find themselves in a distressful waiting position about the resolution of their asylum application.

In 2009 the Danish government made a bilateral agreement with Iraq to send back asylum seekers who were living in the Danish Asylum Camps between 7 – 11 years.

3. National guidelines about children's health-care, education and child welfare

The **Danish Foreign Service** (a department of the Ministry of Refugees, Immigrants and Integration) is responsible for the overall **reception and provision of children** (to asylum seekers, refugees and immigrants) with either short or long-termed residence permit in Denmark. The Ministry of Refugees, Immigrants and Integration (MRI) was created in 2001 to dictate guidelines involving governmental policies. Two corps of legislation regulate this field: Foreigner and Integration laws. Current guidelines about "f**oreigners' introduction program"** refer to adult foreigners who are to engage in an "active citizen contract" with the municipality about rights and

duties. (24) In this document, there are no references to policies about reception of children or to children's needs.

The Danish Foreign Service has out-contracted the care of asylum seekers to the **Danish Red Cross** (as well as Jammerbugt Municipality[2]) responsible for establishing and managing asylum camps and services across Denmark. Asylum seekers are generally placed in asylum centers for reception, accommodation, departure as well as for detention.

Currently the Danish Red Cross (June 2010) manages nine asylum centers, including four special accommodation centers for unaccompanied children, one for reception and two for departure, one for women, and one for families with children who need special care.

The Danish Red Cross has developed guidelines for all professionals to follow considering safety regulations, professional ethics, interdisciplinary management of cases, screening, referral procedures, etc.

The **National Board of Health** (Sundhedsstyrelsen) is the national health care authority in Denmark responsible for organizing health care and the **Ministry of Social Affairs** is responsible for the social welfare of children. It assists the minister of Health and Prevention as well as informs citizens about administration of health care services, health promotion, disease prevention, education and accreditation, planning and quality development, supervision and patient safety, registering and statistics and other health issues.

The National Board of Health's task is:
"… to set the best possible frames within the health care system for the prevention and treatment of illness, suffering and functional limita-tions for the individual. We follow health conditions through monitoring evaluation and endeavor to be at the cutting edge of knowledge and experience." (37)

The local municipalities organize and fund expenses for child-health care and welfare. In terms of organizing and providing health benefits for children it is stated by the "local government reform" (2006):

> *"The municipalities will have the overall responsibility for any rehabilitation that does not take place during hospitalization. Before the reform, this responsibility was shared with the regions. In addition, the municipalities will take over the main responsibility for preventive treatment and promotion of health for citizens residing in the regions. The purpose is to integrate preventive treatment and health promotion with other local services and tasks, i.e. day care, schools, centers for the elderly, etc. Furthermore, the municipalities after 1 January 2007 are responsible for treatment of alcohol and drug abuse. The municipalities are also responsible for specialized dental treatment for the mentally afflicted, etc. which currently lies in the regions."* (33)

The **National Board of Social Services** (VISO- in Danish) (35) is in charge of preventive and supportive child welfare. It acts as a knowledge

[2] Jammerbugt Asylum Center excused itself from participating in this survey due to work overload.

center and offers consultancy to Municipalities and child and youth institutions regarding social matters and special education, including vulnerable children, but not particularly refugee children. The National Board of Social Services is an independent subdivision of The Ministry of Social Welfare founded on January 1st 2007.

The National Board of Social Services aims to promote new developments and initiatives in social services and to support and counsel local authorities in providing services to citizens, i.e. children, young people, socially marginalized groups, elderly and disabled.

The National Board of Social Services is in charge of ensuring that social and welfare policies are implemented in Denmark and to assist local authorities as such policies and initiatives are put into practice in local services. In addition, the National Board of Social Services offers to professionals as well as citizens, specialized consultancy and evaluations in complicated individual cases in the field.

The National Board of Social Services aspires to help securing the welfare of children, young people, socially marginalized groups, elderly and disabled, and to insure that related initiatives reflect scientific research and meet standards of efficiency and documentation.

With a residence permit all families with children between 0 - 17 receive four times a year, a “child-check” from the Municipality’s Child-Welfare Services intended to cover minimum three months’ child-expenses.

The National Board of Social Services has not developed guidelines to follow regarding reception of children to asylum seeking or refugee parents nor for unaccompanied children.

The **Ministry of Education** is in charge of dictating educational programs for basic, special and superior education. “Children with another ethnic background than Danish” are enrolled in a “reception class program” and “language stimulation program in Danish”. (see pp. 26 -28) Besides national programs launched by the Ministry of Education there are also local programs the municipalities carry out. (see p.34-35) It is the municipality’s task to supervise national and local programs progress at day care centers and schools.

Evaluation of preventive health programs and child welfare benefits for children depends mainly on grants and research policies. The Danish National Center for Social Research (SFI) is in charge of research and documentation (among others) about child-welfare. SFI has been in charge of documentation projects about children during their asylum period. (3,4,6)

Evaluation of national programs lies on EVA – Denmark’s Evaluation Institute- in charge of research and development about the quality of educational programs aimed at children and adults. Language stimulation programs are included in EVA’s area.

3.1. Benefits for families with children

Benefits during the asylum period

Asylum seekers' expenses are covered by the Danish Foreign Service (a department of the Ministry of Refugees, Immigrants and Integration). Exceptions to this rule are asylum seekers who are married to a person with residence permit in Denmark, in which case maintenance has to be covered by his/her spouse.

The Danish Foreign Service maintenance of asylum seekers covers (Appendix 7; 28):

- Housing and food expenses
- Necessary medical or social benefits (asylum seekers are not beneficiaries of the Danish Medical Insurance System)
- Education of their children
- Job training of adult asylum seekers
- Transport expenses
- Handicap support,
- Cash benefits including:
    - A cash benefit covering food expenses (in the case there is no cafeteria) and hygiene articles, etc.
    - Additional benefit to those asylum seekers who respect their signed contract with the Danish Foreign Service
    - Additional benefit to asylum seekers with children

Basic allowance in 2010 (28) is 49,10 kr. pr. day pr. adult. If the asylum seeker lives with his/her spouse (partner) the benefit for each is 38,87 pr. day pr. adult. If the asylum seeker finds himself/herself in the first phase, an adult receives an additional benefit of 8,19 kr. pr. day. If the asylum seeker's application is accepted to be considered by the authorities, the additional benefit is raised to 28,65 kr. pr. day. If the asylum seeker's application is rejected and he/she has to leave Denmark the additional benefit decreases to 8,19 kr. pr. day. Both benefits are paid every Thursday with a fortnight's anticipation.

Additional maintenance for 1. and 2. child in 2010 (28): during the first phase is 57,29 kr. pr. child pr. day. If the asylum seeker's application is accepted to be considered by the authorities, the additional benefit is raised to 77,75 kr. pr. child pr. day. If the asylum seeker's application is rejected and he/she has to leave Denmark the additional benefit decreases to 57,29 kr. pr. child pr. day. A decreased additional benefit is given to 3. and 4. child of 40,92 kr. pr. day pr. child. (Appendix 10)

Benefits during the integration period

The Danish Foreign Service designates which Municipality the family will be ushered to, according to certain principles, for ex. spreading-principle where refugees are housed in lesser populated areas. The Municipality's services are

responsible for "**introduction programs"** including housing, payment of "start-help" or introduction allowance for parents, child-expenses, school education, day-care, language teaching, job provision etc. **"Start help"** is the lawful income refugees get during the first 3 years in Denmark (or until the adults get a job) and **"reduced help"** represents the non-working spouse's income which corresponds to half the income of "start help". (7)

Municipalities' services follow guidelines from the Ministry of Refugees, Immigrants and Integration (MRI) about **"introduction programs"** aimed at immigrants and refugees. This program lasts three years and it applies to all "foreigners" over 18 years of age. (24) In this program there is no reference or mention about guidelines to introduce children to a municipality.

3.2. Housing for families with children

Housing for asylum seeking families with children

According to a funded contract between the Danish state and Danish Red Cross, the latter is in charge of providing housing and basic commodities in asylum camps.

Families in the Asylum Camps live generally in small one or two-room apartments, with shared kitchen and bathroom or with their own kitchen and bathroom.(3) Others have family accommodations with two rooms, bathroom and a common kitchen.

Depending on the child's and family's objective health state and supported by recommendations from health professionals, the family may be granted the benefit of housing outside the Asylum Camp in agreement with the local municipality's Child-Welfare Services. (19)

Housing for children during the integration period

It is the local Municipality which actually takes charge of the reception of children harnessed by legislation and regulatives attached to governmental policies. It is the municipality's task where the family was allocated, to find adequate housing usually within the boundaries of its jurisdiction. The child's parents are then enrolled into a three-year integration period. Children are enrolled either in the nearest school or day-care center.

3.3. Health-care, child welfare and education of children

Health-care, child welfare and education of children **during their asylum period** are encompassed in the contract signed between the Danish Foreign Office and the Danish Red Cross. The Danish Red Cross provides health care in the Asylum Camps establishing Health Clinics whose staff is specialized nurses, pediatricians and GPs (general practitioners). Besides, the Danish Red Cross created the Psychological Unit for the purpose of carrying out assessment, screening, preventive and treatment programs with a corps of

psychologists, a psychiatrist and a network of private psychologists as consultants.

Children to asylum seekers according to current legislation are entitled to the same preventive and curative benefits as all nationals. In practice Child-Welfare is organized in the Asylum Camps around interdisciplinary Psycho-social Teams and the staffs are health visitors, pedagogues, psychologists, social workers and family or home-support assistants.

Among others, children who have psychological or physical handicaps are entitled to medical and child-welfare benefits consisting of part time appointed supportive professionals and the right to attend special day-care centers or schools as in the case of deaf, blind or autistic children. Treatments concerning addictions to drugs, alcohol, etc. are only provided for youth up to 17 years old.

In addition children who suffer from neglect, domestic violence or other psychological burdens are entitled to be enrolled in supportive programs according to the Danish Social Service Law. These include foster homes or foster parents, appointed part time supportive professionals, special leisure time activities and nutrition programs.

Health benefits for parents (adults in general) are restricted to "necessary, pain reducing and acute treatments". These core benefits involve referrals to local GPs (general practitioner), emergency wards, some specialized doctors, first consultations with a psychologist, medical and physiotherapeutic pain-reducing treatment, acute dentist consultation and referrals to geriatric services. Pregnant women during asylum period are entitled to pregnancy consultations and a proper health care during delivery.[3] Whereas other types of treatments like psychotherapy, surgery and hospital's treatments, consultation and treatment of cancer or HIV are to be applied for in each case and require acceptance from the Danish Foreign Service.

During **the period of reception as refugees,** children's benefits are regulated according to relevant legislation applicable also to refugees concerning health care, child-welfare (Danish Social Service Law) and education. Health care for the family is in the hands of a local GP, including the children.

Each municipality organizes its child-welfare programs according to their policies and budget. It is usually organized into Family Center and Pedagogical-Psychological Unit (PPR) with interdisciplinary teams of health visitors, pedagogues, psychologists, language-teachers and family or home-support assistants.

Even municipalities with high density of immigrant population have no policies about reception of children to refugees. Joint cooperation about the child's needs for medical or psychological assistance between day-care centres, schools, child-welfare services etc. regarding the reception of refugee children is managed within a framework of the regular collaboration between these parties.

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[3] The case of illegal women who are pregnant and give birth in Denmark is treated in chapter 8.

Integration and Foreigner's laws regulate pension benefits for children's parents according to legal categories: refugees, family reunification or immigrants.

In particular cases, families may apply for extra assistance, for ex. for children with handicap- or other invalidating conditions.

But there are no normative instructions or guidelines about children to refugee families because Municipalities' services do not officially operate with distinctions between children.

Summarily, there are no national guidelines available or formalized procedures for all municipalities' services involved in health care, child welfare or education of children.

Additional information

Since the first refugees came to Denmark in 1956 reception of families and children was mainly in the hands of Danish Refugee Council (NGO) with governmental funding until 2000, when the task of introducing not only refugees but "all foreigners" to the Danish society, was handed over to the municipalities in collaboration with the Ministry of Refugees, Immigrants and Integration.

Recently, the Ministry of Refugees, Immigrants and Integration launched a task-group to explore the situation of children and youngsters categorized as marginalized from the Danish society and its results were published in March 2009 in a report. (27)

3.4. Guidelines and protocols assisting in the reception of asylum seeking and refugee children

The Danish Red Cross has developed their own guidelines and procedures which resemble those children to refugees are subject to. The Danish Red Cross follows a **structured schema** carried out by health visitors from the Asylum Centers. (Appendix 8)

Whereas there are no specific guidelines or structured interviews available for the reception of refugee children in Child-Welfare Services, Pedagogical Psychological Unit or Family Centers.

The Pedagogical Psychological Units are in charge of making assessments and in doing so, they gather information about the child called "anamnese" or "child's description schema". Exceptionally psychologists from Child-Welfare Services of the Municipality of Copenhagen developed a revised version of the **Child's description schema** to broaden information gathering about "children with other language and cultural background than Danish" thus targeting immigrant as well as refugee children. The revised schema extends its enquiry to broader questions about the child's and family's background, languages, past experiences and network.

3.5. Training the staff of the services lies elsewhere: at Denmark's Pedagogical University (DPU), University of Århus, Professional Schools (teacher's schools) and Municipalities' Competence School. Some municipalities have arranged short courses for teachers about teaching Danish as a second language to bilingual children and school-parent cooperation.

It is worthwhile to mention that Denmark's Pedagogical University (DPU) launched in the late 90's a post-graduate one-year course in "intercultural education" for basic school teachers, which unfortunately is no longer available.

Now teachers can apply their basic schools for courses on "teaching Danish as a second language" though access to these courses, is limited to one or two teachers for each school.

Professional schools qualifying basic school teachers recently added intercultural teaching and teaching Danish as a second language in their curricula.

Training of psychologists, pedagogues, health visitors, nurses, doctors and other professions to work with refugee families has not been a concern of the National Board of Health Department or the Ministry of Refugees, Immigrants and Integration.

In the 90's it was mostly Specialized Rehabilitation Centers, Danish Refugee Council, and Danish Red Cross as well as other NGOs, that provided courses about children to refugee families.

Since 2000 the Danish Psychologist's Association has launched two qualifying courses about children to refugee (and immigrant) families.

Joint ventures between municipalities and specialized rehabilitation centers or together with the Center for Transcultural Psychiatry have arranged short courses involving relevant themes about methods and intercultural views to work with families and children, for ex. how to use interpreters.

3.6. Guidelines addressing the request of accredited interpreters

According to public legislation ("Forvaltningsloven" og "Retssikkerhedsloven") it is an imperative for personnel in public service to request an interpreter in case the service's "customer" does not speak Danish. Moreover, personnel have a duty of ensuring a fair communication with the customer. In other words, this imperative means that the municipality in question pays for the interpreter's expenses.

The Ministry of Refugees, Immigrants and Integration gives guidelines (December 2008) in this matter to municipalities. (25) Unfortunately, guidelines give no hint of how these interpreters can aspire to get formal competencies through education and supervision.

Recently a political agreement (May 2010) restricts expenses for the use of interpreters in public services for citizens, who are living in Denmark over seven years. In terms of access to health services it means that refugees (or immigrants), who cannot pay themselves for a private

interpreter are hindered in explaining themselves and understanding GPs and hospital personnel as well as in social services.

There are regulatives in municipalities' services that recommend the use of interpreters when it is necessary. But there is no mention of how these interpreters are recruited, qualified and hired.

It is up to local services to find the appropriate interpreter out of a list from the Ministry of Social Welfare, Regions, Municipalities and private services. In some municipality's services, children or youth are used as interpreters even though it is not recommended.

Most Child-welfare and Health Services use interpreters as routine procedures. But services may not be aware of differences between a professional accredited and an amateur interpreter. Expenses for professional interpreters are higher than for amateurs and the choice of saving expenses may weigh heavier than qualifications. Private interpreter services are cheaper albeit less qualified. Budget cuts in services give way to increasing consultations with a "phone-interpreter" instead of "live-interpreter".

At some Pedagogical Psychological Units accredited interpreters are not present in an interview or assessment of a child. Most children are assessed in Danish by social workers, pedagogues and psychologists, even though children have a rudimentary grasp of Danish and are not familiar with Danish cultural symbols. It is argued that the staff is reluctant to contact interpreters because they rely on the assumption that contact with the child and parents, is improved without an interpreter. Some of municipalities' Pedagogical Psychological Units are very experienced in working together with the same interpreters and develop appropriate interdisciplinary working strategies.

In Specialized Rehabilitation Centers coordination with an interpreter is built in their routines and procedures. Usually interpreters attached to Specialized Rehabilitation Centers enhance their competencies by attending courses and receiving supervision.

At Child-psychiatry Centers contact with parents is promoted by requiring a "live or phone-interpreter". There are procedures and routines to request free-lance interpreters and in some cases contracts with private interpreter's services have been established.

The **Danish Red Cross has an interpreter's service** available for rendering communication possible between the staff and asylum seekers. The Interpreter's Service recruits and evaluates interpreters' competencies. Interpreters are required not to work for the police while they are working for the Danish Red Cross.

It is the staff that requires interpreters for the purpose of health examinations, psychological assessment or other acute assistance of children. In screening tasks health visitors and doctors rely on "phone-interpreters".

There are no standard procedures for recruitment of interpreters and the interpreters do not receive supervision in the Danish Red Cross. There are neither guidelines concerning interpreters' performance and it is the staff who selects those interpreters who to her/his better judgment is best suited for a specific task.

For an assessment task, psychologists tend to choose "live interpretters" who are present while psychologists perform a test battery with a child. It is up though to psychologists and doctors to set time aside to prepare the interpreter for the task, to voice expectations about the interpreter's performance and to promote interdisciplinary cooperation.

Unaccompanied children do not have access to free interpretation unless it is in the context of asylum procedures. But it depends on the attorney to require this service for the minor funded by the Foreign Office.

4. Health examinations and health care for children

4.1. Health examinations of children during asylum period

The Danish Red Cross is in charge of health examinations of children during the asylum period. The examinations are voluntary and require parent consent. They are planned and executed by the medical staff in the health clinics in the asylum centers. The health clinics usually have nurses, health visitors and a GP or a pediatrician. The general health examination includes the child's weight, height, body growth, vaccines, lung-and heart function and sensory-motor development. The first health examination is carried out by a nurse who refers to the asylum center's GP or pediatrician if there is a need for a medical examination.

If during a medical examination of a child, the staff feels concerned about a child's health, they refer the child to further medical examinations, psychological or psychiatric assessments in accordance with the limitations the Foreign Service has imposed on Danish Red Cross' expenses. In 2008 the Danish Red Cross and five municipalities (where the asylum camps are situated) signed an agreement to coordinate assessments and treatments.

The psychological aspect is independent from the medical. In 2007 the Danish Red Cross created an assessment unit for the purpose of providing assessment of children, a task previously carried out by private psychologists. In 2009 a psychological unit replaced the former assessment unit, which is now responsible of psychological screening as well as psychological assessments and assistance programs.

The Psychological Unit is in charge of: screening all families by means of a family interview; treatment for children, adults or family sessions; training and supervision of the staff and specialized assessment of referrals either from the preliminary family interview, day-care centers or school.

Internally within the Danish Red Cross, the psychological unit works closely together with psycho-social teams and health clinics in the asylum camps, which regularly have contact with children and their families.

Cooperative work is established externally with contracted municipalities' services. The professionals involved in the assessment of a child, counsel parents and municipality's services and recommend specific treatments and supportive programs, in due course for municipality services and Danish Red Cross to follow up.

The Danish Red Cross' Psychological Unit started screening all children in 2009. Until May 2009, 109 children have undergone screening. Parents and children answer the SDQ (Strengths and Difficulties Questionnaire); while younger children take the Kuno-Beller Test. Children are physically examined and it also includes interviews with parents about the child's psycho-social and speech development, the child's earlier sicknesses, allergies, etc. as well as burdening or traumatic experiences, the family's flight narrative and the child's competencies. (7)

Screening aims to prevent children with high-risk of medical, emotional and social distress developing medical or clinical disturbances. The goal is to screen children between 0 – 16 years old a short time after they arrive in Denmark. The procedure entails that at their arrival, all families with children are interviewed by psychologists, who report their observations to the psychological unit. Teen-agers are also interviewed together with their parents.

Screening requires parents' consent, though both the child and his/her parents are encouraged to cooperate. Health examinations in the asylum period are covered by health visitors, nurses, pediatricians, psychologists and GPs.

The Psychological Unit of Danish Red Cross published a preliminary report in 2010 with the first results of screening of children with statistical data. (31) Since January 2009 all children to asylum seeking families between 0 – 16 years old are offered a medical as well as a psychological screening during the first three months of their arrival. The purpose of the psychological screening is to identify children at-risk-of-psychological disturbances or those who need special assistance on their arrival "to grant them the best possible living conditions for their development" (Social Service Law art. 11). (31 p.8) Preliminary results indicate that 34% of children between 4 – 16 years old show a higher risk-of-emotional-disturbances than Danish children (considered as background population) and that 25% of the screened children are considered high-risk of developing emotional problems.(31 p. 32-33)

A research project carried out in 2007 in four asylum camps with children between 4 – 16 years old (32) show similar results. Children were diagnosed a higher prevalence of psychiatric problems compared to the general population of children in Denmark. Conclusions from this study reveal a need to identify the causes of these figures and to establish assessment and treatment programs for the children. It was also suggested to study the long-term consequences of poor mental health in children in the asylum period. (32)

Children who are referred due to screening results, by day-care centers and schools are referred for **psychological assessment** to the psychological unit. An assessment may be carried out by psychologists of the psychological unit or by private consultants at an agreed fee.

Although formally the task of monitoring children's health care and welfare during their asylum period corresponds to a cooperative work between the Danish Red Cross and the municipality where the asylum camp is situated, this cooperation does not run smoothly. In many cases children

have to wait extremely long periods of time before they are referred to the municipalities' services.

A legal request for a psychiatrist's assessment applies only in the case of applications for humanitarian residence permit. Grounds to obtain humanitarian residence permit have changed in the last 8 years and now are restricted to "a psychiatric illness of a serious character", usually attached to a diagnosis of "psychosis".

Additional information

It is unlikely that asylum seekers are well informed about the link between asylum legislation and diagnosis of mental health disturbances in applying for humanitarian residence permit. Danish Red Cross does not provide counseling to asylum seekers about their humanitarian residence permit process, so asylum seekers are left to their own devices. Many myths and "hearsay" circulate among asylum seekers who lack sound advice.

Appointed attorneys may either overlook or take the initiative to refer asylum seekers to be assessed by psychologists or psychiatrists guided by their concern about the person's health. In case of an application for humanitarian residence permit, the expenses of a psychiatric assessment are to be covered by the asylum seeker himself unless attorneys argue strongly and request it free of charge for the applicant.

Specialized rehabilitation centers may on behalf of their patients report to the authorities in question, about health risks for a child. For ex. if a child who is treated by a rehabilitation center is to be expelled from Denmark together with his family. Because such a decision may jeopardize the child's recovery, the rehabilitation center may send on behalf of the child a psychological or psychiatric report to the authorities.

4. 2. Health examinations embedded in preventive health programs for children during the integration period

Once the child's family moves into a municipality and their integration period starts children are enrolled in preventive health programs at national, regional and local municipality level.

Health examinations of children from 0 – 17 years old during their integration period are voluntary. Family health clinics or health clinics attached to municipalities, introduce a newborn child to the community. Health visitors make home visits to monitor the child's health by periodic health examinations of children from 0 to 3 years and observations about parent-child relationship.

Health visitors are to report concerns about the child's development, nutritional, medical state or dysfunctional child-parent relationship, first to the child's parents, and secondly, to the family's GP and child-welfare services to act on the child's behalf.

Screening and assessments of children are carried out with the participation of social workers, psychologists, pedagogues, school teachers, GPs and specialized doctors.

Children are enrolled in preventive child-care programs organized by municipalities' services and health services linked to the regions like hospitals, rehabilitation centers for refugees, etc. **Preventive health care** for the children involves periodical dental and nutritional examinations and periodic medical examinations at their GP, including vaccinations according to age, age relevant health examination to children from 3 to 6 years old, special health examination at school start and the last health examination when the child is finishing school in 9th grade. The program includes **preventive dental care** for children between 0 – 17 years, corrective interventions and acute treatment. It is organized by the municipality as a dental clinic or children are referred to private dental clinics for specialized treatments.

In case other specialized assessments are required for ex. neuro-psychological, testing of language acquisition in Danish, etc. the municipality's child-welfare services pays for expenses to private consultants.

In case children with a residence permit are referred to **psychological assessments,** these are provided by the municipality's psychological-pedagogical units or family centers. If waiting lists block a prompt assessment, children may be referred to private psychologists and child psychiatrists.

Additional information

Alike Danish families-at-risk, some refugee and immigrant families do not approach their GPs for preventive health care of their children. Health prevention in general, is a novel concept for these families. Health visitors use their contact with parents to inform them about preventive health examinations and vaccines and urge them to approach their local GP. Sometimes a health visitor goes further and makes an appointment with the family's GP and ensures an interpreter is present because some GPs are not so keen to request interpreters.

Health visitors have observed that the second generation of refugee families is more aware of the benefits of preventive health care for their children.

By and large it was health visitors, who organized in a professional Transcultural Association, and came up with pioneer initiatives in the 80's concerning reception of refugee families. Health visitors argued, refugee families had been exposed to either life-threatening or traumatic events and should be assisted to start a new life in their local community.

To ensure children and their parents a good start, in some municipalities' health visitors arrange extra visits to the family of a newborn child, to get to know the children and parents and find out about their specific needs. In a sense, health visitors become "integration guides" for the family about local services, child institutions, GP, local shops, transport facilities, post office, etc. as well as Danish cultural patterns.

Another initiative health visitors arranged was organizing refugee mothers in **women's groups** to discuss relevant themes, exchange information and talk about intercultural issues. Women's groups worked as an intercultural resource for breaching themes for ex. parenting and child-care. Health visitors imparted knowledge and expectations from the Danish society to mothering and child-care and learned about parenting and child-care from the women.

4.3. Specialized Rehabilitation Centers

There are 13 specialized rehabilitation centers for refugees in Denmark: four in Copenhagen, two in North Sealand, one at Fyn and six in Jutland. They are funded by the Danish regions and municipalities and provide assessment and treatment to traumatized adult refugees (and their family) and torture victims and a few of them include children and youth as target groups. Neither asylum seekers nor illegal persons are target groups of these centers.

Only 4 out of 13 Specialized Rehabilitation Centers for traumatized refugees are qualified to assess and treat children during their integration period. Otherwise children are referred to Child-Welfare Services in their local municipalities where there are no requirements for specialized qualifications of the staff.

In Copenhagen, due to the municipality's decision to cut funds for psychological treatment, parents with traumatic experiences during 2003-2005 were not referred to the specialized rehabilitation centers, unless it was an extremely serious case.

Some of these specialized centers have acquired expertise status, (see p. 22) yet their capacity for assisting their target population - traumatized refugees, survivors of torture and their families – have restricted capacity as it literally shows in the long waiting lists' document published by the Danish Refugee Council. (Appendix 9)

The child and youth psychiatry is funded by the Danish Regions. An assessment starts with a "visitation" by an experienced child or youth psychiatrist, who plans assessment for a referred child or youth. Assessments can be of an ambulant or hospitalization kind. Children admitted to ambulant assessment come to the Child-psychiatry ward every day during some weeks. Hospitalizations of children happen if burdening symptoms call for it.

If the child does not come to assessment, an "outgoing team" visits the child/youth at home and arranges an assessment plan, which may involve hospitalization. Social workers, school teachers, psychologists and psychiatrists work jointly for the purpose of a thorough assessment. Legally, it is the psychiatrist's responsibility to make decisions about diagnosis and treatment.

The child/youth is appointed a "contact person" and his/her parents a "liaison person" to keep them posted. These two professionals are in charge of filling the child's "anamnese" (similar to Pedagogical-psychological Units see p. 14) and to gather information about the child's development and

social background from different sources: GP, day-care centers or schools, other health services and parents. In the course of the assessment, the child is also tested and interviewed by a psychologist.

During hospitalization or ambulant assessment the child/youth is observed by the staff in an environmental therapeutic setting and these observations are recorded to be discussed in staff meetings. Once the psychiatric assessment is finished Child-Welfare Services are contacted and efforts about inter-service cooperation may result in carrying out the psychiatric ward's recommendations. Parents are invited to an information meeting about professionals' recommendations.

Additional information

Some municipalities have developed a considerable expertise about children in their integration period, but work overload, budget cuts and personnel shortage result in flight of expertise.

Knowledge about psychiatric assessments and treatment of children to refugee families is fragmented because it is carried out by private child psychiatrists and to a lesser extent by Child & Youth Psychiatry Wards.

4.4. Expert centers with extensive experience

The rehabilitation centers RCT-Copenhagen, Psychiatric Center Gentofte and the University Hospital in Risskov (the city of Århus) are by the Danish National Board of Health appointed status as national expert centers specialized in treatment of severely traumatized refugees.[4]

4.5. Funding of health examinations

Health examinations of children during asylum period are funded through the contractual guidelines agreed upon between the Danish Red Cross and the Foreign Service. Psychological screening of children is funded with a special grant for this purpose and executed by The Danish Red Cross' Psychological Unit. Recently, funding of the psychological unit was formalized in a signed contract between the Foreign Service and the Danish Red Cross. The health clinics of the Danish Red cross distribute prescribed medication.

Health examinations for children during their integration period are included in the municipality's general preventive child-care programs consisting of periodic medical and dental examinations, whereas psychological assessments are not a part of this program.

[4] RCT's web-site (March 2010)

4.6. Medication or pharmacological treatment

Medication or pharmacological treatment **during the asylum period** are considered core health benefits and funded by the Foreign Service as part of the contract between the Ministry of Refugees, Immigrants and Integration and Danish Red Cross. Other prescribed medicines, so-called "hospital medicines" (which are not available at pharmacies), for ex. medicine for cancer, HIV or strong pain reducing medicine are available for asylum seekers, only in the case the Foreign Service agrees to fund them.

It is the parent's responsibility to provide for medication and prescriptions for their children **during the integration period**. In the case that the family's income is "start help" and they cannot afford prescribed medications or in the case of prescriptions due to chronic maladies, the family's GP can apply for reimbursement from the municipality's child-welfare service.

When children are prescribed medication while attending **child-psychiatric wards** it is the latter that provides medicines and funds it. If it is their GP who prescribes it, it depends on the family's income to cover the expenses and parents can apply for medication benefits to the Danish Red Cross or to the municipality's child-welfare service.

4.7. Information to parents and caregivers

The Danish Red Cross has experienced over the years that parents are most willing to cooperate for the sake of their children's welfare and health care. Very few parents express their resistance. By and large, professionals report that an appropriate approach to parents' resistance gives way to cooperation. Parents learn from health visitors, GP's, school teachers or day-care centers' personnel, about their observations and concerns about their child. Psychological screening was carried out to 94% of the children with parent's consent. (31)

During the integration period, health visitors enacting preventive child-care programs inform parents about health examinations at home-visits when the family moves into a given municipality. Health visitors will further inform parents if to their knowledge, the child needs to be assessed by the family's GP or referred to child-welfare.

In preliminary consultations, specialized rehabilitation centers give an account of the procedures of assessment to parents and invite them to share their knowledge about their children.

At child-psychiatric wards, parents are invited to an introductory meeting to be explained procedures, reasons for referral of their child, planned meetings and visits (in case of hospitalization) as well as to inform about results of the assessment.

In general, there are no statistics about parent's consent, but most services encourage parents' and the child's cooperation.

4.8. Children's needs for acute and/or curative medical, dental assistance as well as psychological and/or psychiatric support or treatment

Children to asylum seeking parents and unaccompanied children who need acute medical, psychological/psychiatric assistance during their asylum period are referred to Danish Red Cross' doctors, emergency wards and GPs.

In case of acute medical emergency children during their integration period are assisted either by school doctors, emergency wards and referred to GP or relevant health institutions. In case a child should be medically examined or hospitalized his/her parents are approached and informed.

School children may on their own initiative approach health visitors and nurses at their school in case of an acute pain or illness.

Acute dental care is provided by municipalities' dental clinics or private dentists.

In case of acute outbursts of psychosis, suicidal attempts, cutting, anorexia nervosa, etc. children may be referred to child psychiatry's emergency or psychiatric in- and out-patient services.

Additional information

Unfortunately, the consequences of life-threatening or traumatic experiences of children are not detected by routine screening methods, GPs or preventive health examinations health visitors undertake.

Children to refugee families, who apparently have settled down, may have a latency period between 1 – 5 years, before they begin to show signs of distress. Day-care centers and schools may either detect or dismiss the child's problems relying on the child's resilience to recover from "foreigner's difficulties".

Observations during the integration period about children, who suffer symptoms of physical illnesses and/or psychological distress after three or five years, do not necessarily have to be associated with traumatization. Yet the latency period for the manifestation of trauma, calls for clinical thoroughness and accuracy.

Long-term mental health's risks for children, who are exposed to traumatic experiences, are modulated by social factors associated with educational levels of parents, the family's economical problems, the buffering role of peer relationships and perceived discrimination. (21) Undoubtedly, this knowledge should be incorporated in reception procedures.

5. Education and day-care assistance

5.1. Education of children during the asylum period

Even though Danish law exerts the right of any child legally registered in Denmark to compulsory and free basic education, "…according to the Danish Aliens Consolidation Act (§42g) of July 8, 2008, the Danish government

provides school-age children to asylum-seeking families with 'separately arranged' schooling although in some cases the child/youth may attend a local municipal school." (40) In Denmark, children to asylum seekers are not given the status of individual rights holders in terms of education (42) and only children up to 17 years of age (not 18) have access to the educational system. (9)

Children living in Asylum Camps in the island of Sealand go to Red Cross' Lynge School. Most children are driven by bus to Lynge School outside the centers (run by the Danish Red Cross), some travelling for two hours a day. In general terms this school follows the "**reception class program"** (see p. 26) created for introduction to the Danish school system for children with a foreign language based on oral and written acquisition of Danish. Lynge School's curricula has fewer hours and subjects than regular municipal schools. Because this program does not follow regular school curriculum it is not validated as school education in Denmark or any other country.

Lessons are in Danish and children are assessed according to their school level. Still it is difficult to match the children individually in their needs and development due to differences in age, resilience, school motivation and family problems.

Teachers at the Lynge School make a big effort to meet the emotional and educational needs of the children against many odds. Many children stay in Lynge School during a relatively short period because they are moved to other asylum camps, get residence permit or are deported from Denmark. Children are emotionally strained by their uncertain asylum situation, their parents' or siblings' health problems so sometimes children stay at home caring for the sick, or they are themselves too distressed to attend school. In general terms Lynge School shows a pattern of high attendance for the younger children and one of unstable attendance in the case of elder children.

Until august 2006 Lynge School had no budget to teach all children in their mother tongue also because it was difficult to match for ex. 14 different languages. Since 2006 Lynge School teaches in mother tongue languages such as Arabic, Bosnian, Serbian, Croatian, Romani, Albanian as well as English as a foreign language. There is no information about the levels and contents of mother tongue classes.

After maximum 2 years in this program children are assessed according to their reading and writing skills in Danish and on their readiness to follow a regular class in Danish. Children who meet both criteria are allowed to attend Municipality's schools of Hillerød and Allerød and sit the exams according to their class level. (4) It has been reported by NGOs that very few children fall into this category.

5.2. **Children in refugee families during their integration period**

Children during their integration period are entitled to the same educational benefits as Danish children: they attend the same day-care centers, basic and special schools, vocational and professional schools, universities, etc.

Danish legislation does not make a difference between children to refugee or immigrant families.

The Ministry of Education is the national agency in charge of educational programs. In recent years the Ministry of Education launched programs aimed at children, who are bi- or trilingual, to learn Danish as a second language. Current programs at national level are twofold:

(i) Continue the program of "reception class" by teaching the children Danish as a second language.
(ii) Children from 3 - 5 years old are enrolled in a "stimulation program of language acquisition in Danish" (2006) organized at basic schools and day-care centers.

At basic schools, teaching Danish as a second language is slowly beginning to be established. Otherwise, bilingual children who need language stimulation in Danish are referred to special tutoring. (40)

The program of language stimulation in day-care centers will be described later. (see p. 28)

5.3. **The "reception-class program"**

This program was launched in the 1980's aimed at "children with a different ethnical background than Danish". Basically, this program relies on the assumption that a two-year intensive Danish language course for children of different languages, ages and different schooling, is appropriate to yield a good start in a regular Danish class. Basic schools with "reception classes" have guidelines about goals, contents and expected results but there are no references to the needs of children to asylum seeking or refugee families.

The program is locally organized according to each municipality's integration and child policies. Municipalities solve problems such as how many pupils a reception class should have; how many school level differences are acceptable; how many different ages and schooling can a reception class cope with and which teaching material is relevant in that particular municipality.

In 2006 the "reception class program" was revised emphasizing the notion that learning only-Danish renders a better start in a regular Danish class. After two years of Danish, it is up to the local school to determine the child's mastery of Danish and his/her readiness to be transferred to a regular class in a basic school.

Procedures aimed at introducing children to regular schools, after their two years "reception class program", are not satisfactory and do not take the child's needs into account. Although the reception class program is meant to be a "reception program", it suspends the child's education concentrating solely on acquisition of Danish, while other subjects go unattended. For a child 11 or 12 years old, two years of unattended subjects matters a great deal even if they learn to speak, read and write in Danish. (22)

Statistics of poor school results and low access to higher educational level for these children are associated among others, with flaws in this program.

5.4. **Stimulation program in Danish language in basic schools**

This program emphasizes language acquisition exclusively in Danish and provides more support to bilingual children in language development.

Even though this program promotes a better integration of children, it collides with municipalities' policies for either scattering or gathering bilingual children. So it depends on which policy municipalities hold to group a sufficient number of bilingual children to justify a methodological change: teach Danish as a second language to bilingual children.

A publication from the Ministry of Education (40) about "language stimulation at basic school level" renders the following results:

- Out of 66 municipalities 33 had not organized the program locally
- Basic schools complain about their lack of influence on procedures by which bilingual children are distributed in a given basic school. Some schools have too many and some have too few bilingual pupils. Basic schools prefer a more even distribution.
- Basic schools hesitate to launch this program arguing they do not have enough bilingual children attending that particular school
- Some schools lack qualified teachers to teach Danish as a second language so this program is not carried out
- Teachers should be qualified to teach Danish as a second language and support bilingual children in other subjects as well
- If bilingual children need pedagogical support, basic schools should have appropriate and age-relevant teaching material
- Basic schools should make efforts to improve cooperation between school and parents of bilingual children
- To be headmaster of a school with bilingual children calls for visibility, decisiveness as well as good leadership
- Need to promote cooperative work between municipality's services and schools about a particular bilingual child.

In general terms, basic schools are in the process of organizing this program, but in half of all municipalities, stimulation of Danish language acquisition in schools and day-care centers are short of policies, procedures, qualified personnel and educational material as well as funding.

Additionally there is a need to design instruments and procedures to measure and monitor bilingual children's readiness as well as to optimize support for children to match mastery of language and school-curricula. Moreover, there is a need to qualify and train personnel, who can test bilingual children to determine the contents and scope of support a particular child may need. (40)

An important task some schools provide is not mentioned in this report. It refers to a special **homework-tutoring program** some schools have organized with great success both for bilingual and Danish children.

Danish Refugee Council and other NGOs also arrange home-work support programs for children with volunteers.

5.5. Stimulation program in Danish language in day care centers

Day-care centers implement the program of language stimulation starting with children who are 3 years old. Bilingual children are entitled to receive language stimulation in Danish 15 hours/week.

Once a year all bilingual children from the age of 3 years old have to be tested independent of parent's consent and tested again at 4 and 5 years old. Language tests are divided into two groups: one aimed at Danish speaking children as their mother tongue and the second, to children whose mother tongue is not Danish.

Day-care centers make yet another distinction between children to second or third generation of refugee or immigrant families: parents who speak fluently in Danish to their children and parents who speak other language than Danish at home.

Some municipalities organize language stimulation and testing by training their staff for this purpose to become language–specialized pedagogues in day-care centers.

Children from 3 – 5 years old, who do not attend day-care centers, are gathered in "language stimulation groups" also 15 hours/week. (15)
Day-care centers and language-stimulation-groups stimulate acquisition and development of Danish by means of play, tours and projects about a chosen theme as well as daily routines.

Additional information

Experienced school teachers in this field recall some of the projects they themselves and colleagues pioneered in the 80's and 90's. While many of the results of these projects were promising, municipalities did not have policies to back these projects up and incorporate results in its routines and procedures. The multicultural approach to bilingual children during the 90's was replaced by restrictions about visibility of the child's cultural background for ex. contributions to literature, art, etc. and devaluation of their bilingual-lism.

Before 2001, the importance of developing the child's mother-tongue rested on legislation that promoted organization in basic schools of language courses in foreign languages according to the pupils' mother tongues. Mother tongue teachers were recruited not only to teach their subject but also were available in basic schools and involved as support-teachers for children, who needed assistance in a regular class. Some schools went so far as to create bilingual classes with two teachers present in most subjects.

Since legislation about language acquisition changed in 2001, schools are no longer responsible for the child's bilingual development. It is left to parents' and private initiative to take over. Changes in legislation and narrow understanding of the bilingual child's development have rendered professional pioneering work to oblivion.

According to EU legislation children have the right to be taught in their mother tongue, but only in EU languages.

5.6. The child's mother tongue is not the teaching-language

Both in day-care centers and basic schools bilingual children are addressed in Danish.

In day-care centers there is a more lenient policy towards children's mother tongue. Pedagogues may encourage parents to stimulate their children in their mother tongue and accept that during a short time, children speak their mother tongue while they are playing together.

While many day-care centers support the child's relationship with his/her parents and family abroad by means of developing the child's mother tongue, basic schools favor a "Danish-only" policy. The child's mother tongue at basic school tends to be suppressed though some children speak their mother tongue while they play during recesses.

In terms of learning, play and adult contact in the context of day-care centers and schools, there is a tendency to devaluate the child's cultural background and render his/her mother tongue irrelevant.

It has been observed that bilingual children, who do not have a formal education in their mother tongue, do not have the same fluency, abstract comprehension or vocabulary in their mother tongue compared to Danish as their second language. Contrary to expectations children do not reach mastery of the Danish language through Danish-only strategy.

Parents of different language backgrounds have pioneered projects about teaching their mother tongue to school children. These projects usually disappear due to lack of either public or private sponsorship.

6. Child welfare

6.1. Child-welfare for children in asylum or refugee families

This is integrated into the general child-welfare services funded by the Municipalities. Furthermore, the Municipality's Services cover to some extent, the welfare of children during their asylum period relying on joint cooperation with Danish Red Cross.

According to Danish legislation refugee children have the same access to preventive and supportive child welfare as any other child in Denmark. If restrictions occur, it is a matter of how municipalities organize preventive and supportive programs for all children.

Children in refugee or asylum-seeking families can also get **extraordinary assistance** if they fall into risk-groups for ex.: parent's

neglect, parents with psychiatric disorders, single-parent's families during their asylum period or integration period, alcoholic or drug-addict parents, intra-familiar violence or sexual abuse, etc. Children may require extraordinary assistance too in case they are diagnosed with recognized diseases or handicaps, for ex. autism.

Assessment of a child in the child-welfare services follows basic procedures. Referrals are based on observations about a child by The Danish Red Cross' staff or from day-care centers, schools or special schools. These referrals carry some data about the child and observations from the institutions responsible for the referral.

All instances associated with the child's health and welfare are contacted: GP, health visitors, day-care center, school and other relevant sources. Clinical interviews with the child, his parents and siblings may follow. Psychological assessment and medical tests may be required to ensure precision of evaluation and diagnosis. Once all the results are analyzed and studied parents and the professionals involved with the child are invited to a network meeting to learn about recommendations on treatment and supportive programs.

6.2. Procedures of intervention in case of neglect or dysfunctional behavior of a child or parent/caretaker

Concerns about children in **asylum seeking families** follow similar procedures as for refugee children but is managed by the Danish Red Cross. Children are referred for psychological assessment and treatment by pedagogues, health visitors, social workers and teachers. The case of unaccompanied children is treated elsewhere. (see p. 39)

Observations from Day-care centers are very useful because children during their asylum period tend to hold their traumatic experiences to themselves. Sometimes a child is observed to become extremely distressed the moment he/she has to say goodbye to his mother at the Day-care center. In this case, the introductory phase to the Day-care center for these children with "separation anxiety" is carefully planned to prevent the child's mounting distress and anxiety.

Younger children, who have witnessed violence against someone they cared for, for ex. beatings and rape of their parents or loss of a parent, may show repetitive or aggressive play.

Referrals of elder children are due to learning and concentration difficulties, sadness, introversion, impulsiveness and social isolation. Children may take upon themselves adult responsibilities at an early age due to parental disability.

According to current legislation the procedure of intervention is the same in cases of neglect or dysfunctional behavior in **refugee children under the integration period** as with any other child in Denmark. It is usually day-care centers, schools or health visitors, who notify the local Municipality's Child-Welfare Services to intervene and it is up to that particular municipality to define procedures of action according to current legislation and budget.

Interventions start with the referring institution (school, day-care center, health visitor, etc.) gathering facts and information about the child. It happens sometimes that facts in the child's record are missing, show contradictory information and carry assumptions which are not corroborated.

Even though a teacher can read on the school application that the family comes from for ex. an African country, she/he has little knowledge about living conditions, language and cultural features in urban or rural areas, as well as differences between African countries for a child's upbringing. The child may be bi- or trilingual and share a multicultural background with his/her parents as well as siblings and family members, who are not present in their daily life in DK.

Incongruencies about the child's background and the teacher's uncorroborated assumptions about the family can lead to misfortunate meetings with the child's parents. Especially because, it is the teacher who has to inform parents, that the school is about to refer their child for an assessment. On the other hand parents may feel ashamed and blamed for the child's problems and thereby are not too keen to share their past with the teachers. Furthermore parents who have been through traumatic experiences do not wish to expose their children to stigmatization.

Once data collecting is accomplished the child may be referred to Pedagogical-psychological Unit for psychological assessment or to a specialized rehabilitation center.

Referrals to specialized rehabilitation centers in case of neglect or for any other reasons are done by a GP as: (i) only-child, (ii) only-parents or (iii) whole family referral to assessment and treatment.

A child can be referred by their GP or by doctors at maternity wards, if a mother is assessed to be unable to cope with a new-born child.

Causes of referral to specialized rehabilitation centers are described by GPs in general terms, for ex. "the child is not thriving" or "the child is affected by his/her parent's distress or illness". If a doctor's referral involves all family members, children are called in for interviews together with their parents. If it is the adults who are referred, parents are invited to share their concerns about their children.

At the Specialized Rehabilitation Centers, parents are invited to join in a preliminary exploration of the family's views, for the purpose of assessing the scope of the family's problems and resources, as well as introduce the family to the procedures of "assessment".

Children are asked about their problems at family interviews, for ex. if they have been separated from their parents, about how they sleep and about physical pains or aches. For ex. children might report about pressing themselves to stay awake for fear of nightmares and worries about their parents. Some of the symptoms children describe resemble their parents', for ex. anger, anxiety, sleep disturbances, emotional distress, etc. In some cases, especially girls, take upon themselves the burden of parental concern and care for their siblings and parents as well as household tasks, sacrificing their leisure time and school homework in this endeavor.

During family interviews observations about parent-child, sibling's relationship and ways the family talk or keep silent about their strains and burdens are assessed.

The next step implies sharing information and cooperation between the municipality's Child-Welfare Services and the Rehabilitation Center. To discuss and take joint decisions about a plan of action several "network meetings" with the parents and relevant professionals are planned. (see p. 36)

This joint cooperation results for ex. in appointing a part time support-teacher at school or at a day-care center relying on environmental therapy, the child may be placed in a special school or referred to child psychiatry for further assessment and treatment.

Referrals to child psychiatric wards are related either to parental inability or the child's own problems. Referrals may be associated on the one hand to parents' impaired social or parental competencies or by traumatization.

On the other, children can be referred because they show signs of aggressive symptoms, anxiety and resistance to attend their school or day-care center, difficulties with social functioning, concentration problems, unrest, lack of social competencies, etc.

Child psychiatry seeks to isolate the child's own troubles from the family's social strains and burdens. The child can be assessed as ambulant or hospitalized for observations. The child is closely observed specially his/her social competencies, in an environmental therapeutic setting at the psychiatric ward. The next step is to inform the child's parents about the results of the assessment and establish cooperation between Child psychiatry and the municipality's Child-Welfare Services.

6.3. Restrictions

Restrictions are associated with cost-benefit strategies for funding health care benefits as well as shortage of personnel. By and large there are no formal restrictions compared to children in general. However, studies indicate that there are differences in the way in which Child-Welfare Services manage the cases of children to refugee and immigrant minorities.

Because child-welfare services have an enormous workload and a shortage of personnel, action plans can take longer time than recommended.

Therefore, restrictions are due to work overload for child-welfare service's personnel, who cannot give the same attention to all cases, which in turn may result in neglecting certain cases of refugee children. It can take a long time for child-welfare services to get involved in these cases, coordinate their efforts, make decisions and fund programs.

In some unfortunate cases children's problems go undetected. For ex. the case of two brothers who had not been to school for many months and neither the children's school nor their parents asked for assistance.

For instance children to ethnic minorities may be neglected because child-welfare services tend to blame "cultural practices" and are reluctant to interfere with alleged "cultural traditions". For ex. a child to a dysfunctional

father was showing signs of distress at school, but the exploration of the case came to a dead end by explaining the father's psychiatric disorder with "alleged parental practices", an assumption that was not further explored. Such an explanation would not possibly hold, if it were the case of a Danish family.

Although there are no statistical figures, day-care center's staff report that children to refugee or immigrant families are referred more often to child-welfare services than Danish children. Children to refugee or immigrant parents may be described more often than Danish children, as "under stimulated" in the sense that child-parent exchanges do not mirror Danish parents' "cultural practices". Usually it refers to norms about how parents should relate to their children. For ex. a social worker or psychologist may describe as a cause of under stimulation, that parents do not read bedtime stories to their children, talk to them about their day at school or in the day-care center and do not even use Danish in their communication with their children. These descriptions do not take into account that parents talk to their children about other topics at other times and because they cherish their mother tongue, wish their children to acquire it. Quite often, descriptions of what actually happens between parent and child tend to reflect a negative view of ethnic parents' norms and values compared to Danish.

To a lesser extent than ethnic Danish children, children to immigrant or refugee minorities are allocated in foster families. Instead they are referred to specialized children's homes (døgninstitutioner) which in general, are not qualified to work with refugee children and their parents. Undoubtedly there is also a general lack of qualified foster families who are willing to meet the needs of children to refugee and immigrant minorities.

Restrictions may be due to the practice of "cultural homogeneity" by basic schools. Teachers rely on "cultural homogeneity" assuming that Danish children share a common language and cultural heritage and therefore it is not relevant to have detailed information about the child's background. Children to refugees (or immigrants) do not fit into this principle because the child's past, present and his/her family's background in most cases do not resemble Danish children's background.

Because of legal limitations the child's medical journal cannot be transferred from The Danish Red Cross to the child's GP (or other health institution) without parent's consent, and it may happen that the child's GP, day-care center or school does not get relevant information.

Schools may underestimate the child's traumatic experiences because the staff is reluctant to explore this issue with the child's parents. Teachers explain this attitude as an evasive strategy to avoid embarrassing or causing disruption in communication with parents.

Structural restrictions refer to invasive and intrusive mistrust factors present in communication between parents and teachers or day-care center's personnel. It is observed to contaminate teachers' and sometimes parents' efforts to get a point through to the other party, blocking chances for cooperative understanding. Parents may mistrust day-care centers' personnel

of not caring enough about their child and teachers may become defensive and protect themselves from being misread as “racists”.

To counter mistrust the staff may become over involved rendering the teacher unable to identify the problem in its right perspective and hesitate to apply methods and tools, which before have proven to be successful.

Feelings of impotence might shake the teacher’s confidence about her/his own pedagogical competence and personal resources resulting in “compassion fatigue” and sick leave.

6.4. Leisure time activities for the children

Children under the asylum phase have limited access to leisure activities compared to Danish children. There are usually no playgrounds for young children in the asylum camps. Otherwise young children can play in the Day-care centers and for elder teen-agers they can join Youth Clubs which organize activities. In some asylum camps, there are football or basketball courts.

Otherwise The Danish Red Cross facilitates a network of volunteers who arranges activities for the children according to their age and interests including leisure time activities, language training, etc.

Children under integration have access to free-leisure activities organized by the municipalities where they live. Children can also participate in other activities if parent’s can afford the fees or receive benefits from child-welfare services to cover professionally recommended free-leisure activities.

NGOs play a role in providing volunteer programs of “bridge-making” between children to refugees and volunteers, who may be Danish students, pensioners and professionals. Among others, the Danish Refugee Council facilitates a network of volunteers, who participate in the reception of refugees. About 4.000 volunteers offer their efforts to help children with school homework, introduction to the local community including leisure time activities, language training, etc.

6.5. Good examples of strategies of collaboration

The Danish Union of Teachers and the Danish Association of Social Workers carried out an interesting project in 2007-2008 called **“Take care of every child”** (“Hånd om alle børn”) aimed at improving inter-service collaboration to support vulnerable or marginalized children. The project included but didn’t specifically deal with refugee children. Five municipalities participated in the project. They are Faxe, Herlev, Fredericia, Rebild and Århus. (1)

The Danish Refugee Council carried out a project in Århus denominated **”Information about PTSD aimed at school children and professional networks”**(“Vidensformidling om PTSD til skolebørn og deres voksne netværk”) (2001-2003). Children were taught about PTSD as well as

their teachers, social workers and other professionals involved in child welfare and education.

The Danish Refugee Council applied the Ministry of Integration (2009) for a grant to fund a similar project in Copenhagen inspired by the experiences in Århus. Besides teaching about PTSD, Danish Refugee Council's intends to improve the inter-service cooperation between professionals, who work with the children.

The Danish Psychosocial Rehabilitation and Information Center (Videnscenter for Social Psykiatri) took the initiative to start a program in 2003 -2004 involving some districts of Copenhagen and suburbs. The program targeted out-patients in adult psychiatry, specifically mothers of another ethnicity than Danish with young children, identified as a risk group.

The program **"Ethnic minority women as out-patient group-at-risk"** (35) aimed to provide and promote joint cooperation between municipality services and adult psychiatry and thereby act as buffer for these mothers and their children.

All professionals from municipality services and social psychiatry involved with a particular mother and her child (or children) would meet periodically to discuss action plans, identify tasks and coordinate efforts, for ex.: heath visitors, pedagogues from day-care center and adult psychiatry, family support assistant, parent's social worker, child's school teacher as well as child's social worker were all invited.

Because health visitors were usually the first contact with the family, the health visitor became the "reference-person" for this mother and her children as well as for all the other professionals working with this family.

The reference-person was in charge to lead the group meetings, delegate tasks and coordinate the decisions taken at these meetings. By exchanging information about the family, the professionals learned, for ex. the mother was a traumatized parent, who could not sleep at night and was burdened by nightmares. Health visitors observed her children were also affected by her problems. Their sleep was restless and anguished; they were emotionally distressed and expressed the family's strains and burdens in different ways according to age and individuality.

The mother was enrolled in a treatment at a Social Psychiatry Center, and went to language lessons in a specially designed group for traumatized adults. Her children were also taken care of and enrolled in supportive programs relevant for the children.

Different issues were discussed at joint cooperation meetings with the parents, for ex.: Danish "cultural" expectations about the appropriate age children should have control of their sphincters, how long parents should bottle-feed their children; knowledge about how day-care centers work with children as well as underlying pedagogical assumptions. These issues were followed up by the health visitor in home-visits to the family.

A good example of a health visitor acting as "reference-person" was the case of an initiative of introducing a child and parents to a day-care center. Parents were notified about their child's start in a day-care center and invited to participate in an introductory meeting with the day-care center's staff in charge of their child.

An interpreter was requested and parents were introduced to day-care procedures, expectations towards parents and planned activities for the children. Parents were asked to share information about the child they meant was relevant for the day-care center to know about.

A month later another meeting was set up with the same participants: day-care center's staff, health visitor and parents to check up on how parents perceived their child's start at the day-care center and how the staff perceived the child's and parents' efforts. Again three months later another meeting was held to ensure fluent communication with the child's parents. At this meeting, it was decided that the child's pedagogue at the day-care center, would take over as "reference-person", thereby become leader of joint cooperation for all professionals involved with the family. Actually, it meant that both parents and professionals could refer to the "reference-person" in case any problem would arise and the parents needed support to solve it.

Qualifying courses were arranged for day-care centers' and adult psychiatry's pedagogues, health visitors, social workers, etc. to enhance their understanding and pedagogical interventions with the target group.

In spite of its success, joint cooperation between the municipalities' services and adult psychiatry was not incorporated as a regular procedure in the participating services nor in out-patient psychiatry centers.

RCT in Copenhagen started in 2005 a project denominated **"network meetings",** gathering all implicated parties of a "referred person or family" into a professional network together with the patient. (20) The project aims at reducing the negative implications of cost-benefit policies, fragmentation and "optimization" of Municipalities' services. Professionals involved with the same family are organized in different services which do not communicate with each other. On the one hand, the family has to deal with professionals who are not aware about their colleagues' efforts in other services. On the other hand, professionals lack the overview to make a relevant intervention.

RCT's Rehabilitation Department acts as bridge-maker between the services and establishes a professional network around a referred person or family. In this network professionals may share information, identify tasks and delegate responsibility, while RCT coordinates efforts and upholds an overview of the "case". The project's goal is to improve collaboration between refugee families and their professional network as well as within services.

The following is a **case example** by social worker Bente Midtgaard, RCT-Copenhagen about a refugee family.

NN came to DK from Iran with his wife and 2 children and a newborn baby was added to the family during their asylum period. NN had been a political leader and was imprisoned for a total of 8 years, but had been denied asylum in DK. NN lived during 4 years in a Danish Red Cross's Asylum Camp and struggled for his right to asylum. In an act of despair NN attempted suicide and later went on a hunger strike. Amnesty International and RCT joined forces on behalf of NN and his family and finally NN was granted asylum.

According to the reception program NN, his wife and by then three children were allocated in a house far from Copenhagen city. Even though the house had 4 rooms, the family was only permitted to use 2 of these rooms as well as the kitchen and the bathroom. The 2 other rooms were locked up and kept this way in case the Municipality needed them for other refugees.

The family organized their living quarters so one room was used to sleep for 2 adults, 2 teenagers and a baby and the other room used as a living room. The eldest boys, who were 14 and 16 years old, had difficulty getting enough sleep with a new born crying at night. To be able to concentrate in their homework the boys sat in the corridor where the light kept going out every 8 minutes.

NN's friends and network lived in Copenhagen so NN felt isolated and bereft from social support. NN believed that the Foreign Service and the Municipality housed them under these unfavorable conditions to retaliate for the negative public attention his case had caused them.

NN`s identity was based on being a political activist. He had fled his country and felt ashamed for being safe when his friends and colleagues were not. He needed something constructive to fight for in Denmark.

NN was experiencing mounting distress because he did not feel respected and unfairly treated by the Municipality. He got into a fight with the municipality's staff and both sides escalated the conflict. NN had difficulties in controlling his anger and felt impotent about the injustices he felt he was subject to. The conflict took up all his attention and negatively impacted not only upon himself, but on his entire family as well.

Even though NN`s wife was a strong woman and a caring mother, many years of persecution and insecurity had done their toll. She was about to separate from NN in order to protect the children. When the family was referred to RCT they were about to fall apart as a family. RCT responded to the situation with a plan for the whole family.

The following rehabilitation plan was set up to help the family:

- Find an appropriate flat for the family
- Apply for financial support to fund furniture, clothing, and moving expenses
- Apply for funds for NN's medication
- Apply for financial support for leisure time activities for the children
- Act as mediation party and build a "bridge" between the family and the municipality's services
- Counsel and support the mother's educational aspirations
- Recommend granting incapacity benefit for NN
- Apply for special Danish language lessons at home for NN
- Invite a volunteer from the Danish Refugee Council, so that NN could practice Danish at home
- Suggest occupational possibilities
- Interdisciplinary treatment for the whole family

NN and his family started on an interdisciplinary rehabilitation at RCT coming to regular sessions with a psychologist, a physiotherapist, a physician and a social worker. The whole family came to see the family therapist. The physiotherapist treated NN and recommended aid facilities. The physician took care of medication while the social worker had sessions with both parents especially about the conflict between NN and the authorities.

For a Danish family with many problems it becomes very demanding to cope with a fragmented and cost-benefit driven social welfare and they can be torn apart. In the case of traumatized families the consequences are wide more disruptive.

The psychologist and the social worker were concerned about NN`s obsessive struggle against the authorities so they worked together to alleviate the family's emotional strains and take practical steps to solve the conflict. Together with the family RCT planned how to approach the municipality's services. NN needed to know about his rights and duties as welfare client and the municipality needed to understand his situation to assist him.

In the beginning of NN's rehabilitation the social worker had many disagreements with him. NN thought of the social worker as a professional who did not agree with him neither in his cause nor on his ways of fighting back. By talking about disagreements and finding other ways to solve the family's problems, slowly but firmly, the social worker and NN established a working relationship.

RCT invited all the professionals dealing with the family to a series of planned professional "network meetings" (see p. 36) – four different social caseworkers from the municipality, the boys' school teachers, the youngest boy's day care pedagogue and NN's Danish teacher joined in too. The fact that the family was living on "start help" caused the family to live in extremely poor economical conditions compared to average Danish living standards. Even though the family was entitled to receive extra benefits the Municipality's services had rejected their claims.

RCT was successful with this family building up a cooperative professional network to join in and coordinate their efforts to solve the family's problems. Several meetings took place with the participation of the family together with the professional network and responsibility for concrete solutions was delegated and evaluated.

When the rehabilitation treatment was coming to an end the family situation had improved tremendously. At this point of NN's rehabilitation, the results showed that he was more relaxed, slept better end even regarded the authorities in a humorous light.

NN was granted an incapacity benefit and although he was physically handicapped with chronic pains, he became a volunteer in Amnesty Denmark and his self-worth was attached to something he really believed in. His wife was studying and received her own income and the family was free of extreme poverty. They had a decent flat which they made their home; their children were doing well and happy that their father was available for them. NN had learned quite a lot of Danish and knew where to require help if his family needed it.

The social worker proposed NN to participate in interviews for a campaign with Amnesty International against the laws of “start help”. NN was interviewed in different occasions and was happy to be part of a good cause because it made him feel useful.

Not only NN and his family were beneficiaries of this rehabilitation process. The Municipality’s services involved in this case as well learned about positive ways to relate to a traumatized refugee family.

7. Special concerns regarding unaccompanied minors

The Danish state has handed over the task of housing, feeding and protecting unaccompanied children to The Danish Red Cross.

7.1. Boarding homes for unaccompanied children

Children up to 17 years old are housed in 4 special boarding homes for unaccompanied children: Center Gribskov, Sjælensmark, Vipperød and Avnstrup Annex. They are cared for by professionals of the Danish Red Cross. The children’s nutritional state is monitored by nurses and the children either cook their own food or eat the Center’s food. Children are monitored 24 hours by professionals and every child is appointed a “contact-person” among the Danish Red Cross staff. (3)

The Foreign Service Office delegated the task of assigning “custodians” of unaccompanied children to the Danish Red Cross. Custodians are not responsible for the child’s care or welfare but are considered to be the child’s legal representative in relation to the Danish authorities. The Danish Red Cross has established a corps of volunteers from different walks of life under the denomination of “parent representatives”, who are assigned one child at a time. These volunteers receive periodically supervision from a psychologist of the Red Cross. Because unaccompanied children and “parent’s representatives” do not share a common language they use the Danish Red Cross interpreters in those occasions when it is absolutely necessary.

Center Gribskov is divided in three main sections: reception quarters, child & youth home and youth home in the city. While the youngest live in the Center itself by a forest, the eldest can move out to Municipality’s youth home in Hillerød city and assisted by an appointed professional of the Danish Red Cross. (3)

Some of the children can apply for foster care if the child prefers to live with relatives who have residence permit in Denmark.

7.2. Providers of unaccompanied children’s needs for health care, education, leisure time and welfare benefits

The Danish state has contracted health care for unaccompanied children to The Danish Red Cross. These benefits are funded by Danish Regions, and the Foreign Service. The Municipality of Gribskov is in charge of assisting children with special needs for health and welfare benefits following current legislation.

Unaccompanied children are subject to preventive medical and curative programs established by the Danish Red Cross with specialized personnel of nurses and doctors. If health or other examination is required for unaccompanied children in the course of their asylum process, it is provided by Danish Red Cross' Psychological Unit, Health Clinic or private doctors.

In addition unaccompanied children have access to health and welfare benefits for ex. dental care, hospitalizations, surgery, psychological consultations, specialized doctors, skin clinics, physiotherapist, etc. all of which may not exceed the cost of 5 consultations. Further treatment depends largely on the professional's assessments about the child's health state and recommendations for further treatment as well as the Foreign Service's policies about funding health care for unaccompanied children. (3) (17)

Unaccompanied children who show psychological distress such as: grief, anxiety, sleep troubles, head and stomach aches, insecurity, learning difficulties, etc. are assisted by the Center's appointed professionals and referred to the Danish Red Cross' Psychological Unit and further to GP, psychologists or specialized health professionals outside boarding homes. (3) Unaccompanied children can also be burdened with homesickness, separation-anxiety, boredom, depression - feelings of powerlessness and meaningless, as well as addicted to drugs and engaged in criminal behavior.

Some of the unaccompanied teen-agers tend to disappear quite suddenly from Danish Red Cross' Asylum Camps. Some travel further to other European countries seeking relatives, work and a place to settle down.

Children who show psychiatric disturbances or conditions can be referred to, assessed and treated by private child psychiatrists. (see p. 21)

Among unaccompanied children only few cases of **trafficking of children** have been exposed. These children are not considered asylum seeking children (even though they are minors) and are housed into Danish Red Cross' Reception Centers together with adults and usually deported from Denmark.

7. 3. Education for unaccompanied children

This follows the agreement between The Danish Foreign Office and The Danish Red Cross to provide unaccompanied children with 'separately arranged' schooling and in some cases the child/youth may attend a local municipal school. (see p. 25)

During the first eight weeks the children receive lessons from teachers in the Reception section. Because of the big differences in age, development and level of literacy, lessons are individually planned and aim at the child's "adjustment" and "language-acquisition in Danish". Emphasis in acquisition of basic oral and written Danish is thought to speed the process of "adjustment".

Later when moved to the Child & Youth Home, children attend the Danish Red Cross School in Lynge. The school receives its guidelines by Center Gribskov, for ex. guidelines for teaching illiterate children.

Minors attend Lynge School and elder children attend regular schools in the municipality where they live. At Lynge School the children follow the "reception class program" (see p. 26) based on oral and written acquisition of Danish. Because this program does not follow regular school curriculum it is not validated as school education in Denmark or any other country.

After maximum 2 years in this program children are assessed according to their reading and writing skills in Danish and on their readiness to follow a regular class in Danish. Children who meet both criteria are allowed to attend Municipality's schools of Hillerød and Allerød and sit the exams according to their class level. (4) It has been reported by NGOs that very few children fall into this category.

7.4. Juridical protection in asylum laws and procedures regarding application and family reunification

Unaccompanied children's applications are subject to the laws of asylum just like adults'.

Attorneys involved in asylum cases are recruited and funded by The Foreign Service, on a limited basis: only 9 hours per case. Otherwise applications for humanitarian residence permit are not funded at all and the child have no access to free legal aid.

Unaccompanied children cannot appeal the authorities' rejection of their application and have access to legal aid. Once their asylum process is finished and their application is rejected, unaccompanied children are not entitled to legal appeal or free legal aid.

7.5. Information and advice to unaccompanied children

Information about their own application is provided by the Foreign Service in general terms – but it is not personal advice associated to their application. Applicants may access information about asylum and advice about family reunification in the Danish Refugee Council or other NGOs using their legal expertise to advice applicants.

In the case of **humanitarian application,** unaccompanied children do not have access to free psychiatric assessment unless their attorneys (acting on good-will) apply for it.

7.6. Determination of age for unaccompanied children

Children as applicants are examined by Forensic Medical Institute (Retsmedicinsk Institut) to "objectively" determine their age. Health examination roughly consists of assessing bone growth and genital maturation and is funded by the state. The purpose of age determination builds on the state's burden to prove or dismiss the unaccompanied child's alleged age. In rare occasions and depending on the attorney's legal arguments, unaccompanied children can get funding for a second opinion on age determination from another health service.

In case an unaccompanied child in his/her asylum application claims to suffer from torture consequences, this child may be referred to the Forensic Medical or Psychiatric Service (Retspsykiatrisk Institute) for an assessment, for the purpose of confirming or dismissing his/her claim.

7.7. Leisure activities for unaccompanied children

For unaccompanied children the Danish Red Cross in Center Gribskov has appointed three staff members to plan, organize and execute leisure time activities for the children together with volunteers of the Danish Red Cross.

In the Center Gribskov children have fast scheduled activities three times weekly according to their ages and interests. Children have access to PC and are tutored in IT-programs and have a weekly swimming session.

Once a week the older children go to local Youth Clubs in the evenings, to meet other youth and have access to PC and games. Once in a while, they are invited to parties arranged by Danish Youth Clubs in town.

There are **limitations or restrictions** for the children to attend these activities. On the one hand Danish Red Cross' budget shortages restrict the span and number of activities for the children. On the other, unaccompanied children cannot afford the expenses of local leisure time activities arranged by the municipality.

NGOs provide free-activities for the children, for ex. when NGO-Danish grandparents and their grandchildren spend a day playing with the children of the asylum camps.

Very popular among Center Gribskov's children are the local sports competitions organized by **local Sports Clubs**. Other activities are organized together with The Danish Red Cross' volunteers who invite the children home or to an outing. (3)

8. Illegal persons in Denmark

8.1. Benefits for illegal persons

Illegal persons living in Denmark are neither beneficiaries of Asylum benefits nor from the Danish Social and Medical Welfare System. In cases of emergency their medical and dental assistance can be covered by the Danish Foreign Service. To some extent they can receive maintenance benefits. (29)

Benefits to children to illegal parents depend on the legislation the local municipalities and basic schools rely on and on volunteer work from NGOs.

8.2. Illegal women giving birth

The case of illegal women who are pregnant and give birth in Denmark has been debated recently in the Journal of the Danish Midwives Association in

two articles (39 & 40). It is the case of former asylum seekers, former au-pairs, prostitutes, or former tourists without visa.

The Association of Midwives acknowledges there is a problem with the juridical interpretation of these women's need for assistance during their pregnancy and childbirth. So far it has been a common practice in Danish public hospitals to assist these women as "paying customers" and ask for a deposit of approximately 40.000 kr. to cover their expenses of pregnancy examinations and care under childbirth. Because illegal women usually have no economic means and cannot pay such a large sum, they do not receive periodic pregnancy consultations and usually wait till the last moment to be assisted in childbirth wards when they have to give birth. Midwives Association shares their concern because this practice can be detrimental for the child's health and future development.

According to the current Danish interpretation of legal documents childbirth is not considered as an acute intervention unless medical reasons dictate it. The Ministry of Health's recommendations in 1999 informed that pregnancy and childbirth for these women should be free of charge.

Yet, the article (38) cites juridical consultant from the Ministry of Internal Affairs and Health Jette Vind Blichfeldt: the former practice of considering illegal women as "paying customers" is illegal. Women should be examined and if the mother's or the baby's health state is not assessed as acute, she has to be referred to private midwives or private hospitals.

In other words, health care during pregnancy for illegal women is not a responsibility of the Danish public health system. Nevertheless some midwives, who do not agree on this interpretation of international legal agreements, assist illegal women as far as they can. (39)

Children born to illegal mothers are registered in the Church Office (in charge of all birth registrations at childbirth wards) and get a transitory id-number as illegal children.

9. Other comments

9.1. General problems on the organizational level for providing health examinations and psychological assistance

The fact that children do not attend regular day-care centers and schools and are not mingling with other children than asylum seekers at everyday basis, raises a question about protective factors to promote recovery for children to asylum seekers. Especially those children exposed to protracted asylum should be considered as a group-at-risk.

The Danish Red Cross relies on two programs for children: STROP and "psycho-education". STROP, which stands for structure, talk and time, rituals, organized play and parents support, was created by the pediatrician Lars Gustaffson in Sweden as a supportive psycho-pedagogical environment, which is applied in day-care centers and schools in the Asylum Camps. It is

understood to provide a buffer against secondary traumatization and to promote restitution for children.

The other intervention is arranged by the Danish Red Cross' Psychological Unit denominated "psycho-education" for children. It is based on age-relevant trauma-interventions inspired by Dr. Bessel van der Kolk's Trauma Center, Justice Resource Institute, Boston, USA.

Relevant to prevention efforts seems a discussion whether day-care centers and schools at Asylum Camps or regular day-care centers and schools in the community, are the most suitable psycho-pedagogical environment to provide protective factors and promote children's recovery.

There is a structural and organizational problem blocking children's access to effective and timely health benefits linked to assessment procedures. Complaints about extremely long waiting periods for a child to be assessed and treated in local pedagogical psychological units and child psychiatry are common place. It is our contention, that this time-lapse does not favor children's recovery.

The general impression is that teachers and pedagogues do report to Child-welfare Services their observations about a child's first signs of emotional distress, social inadequacy or learning impairment as blocking the child's development and progress.

Due to work overload it takes longer for professionals at Child-Welfare Services to start an exploration of the "case" by following stipulated procedures.

The next step is to enroll the child in an environmental therapy program with support from a supplementary teacher or pedagogue in the day-care center or school class the child attends, as well as at home. Environmental therapy builds upon Danish culturally modulated interpersonal codes and in many cases Danish children, who are exposed to interventions with this therapy, rapidly recover.

Children who do not show progress and are not helped by environmental therapy are once again referred to another health service for ex. private child psychiatrist or neuro-psycho to receive an appropriate diagnosis and treatment.

Assessments by Psychological-Pedagogical Units have restricted options because according to current legislation on child-welfare psychologists, social workers, pedagogues, etc. are not qualified to make a diagnosis. It is in the hands of doctors in other health services, to make an assessment and recommend a treatment. The time-lapse between the first observations and treatment for these children grows due to inflexible referral attributions of the services.

There are no statistic figures about referrals to specialized doctors before or after environmental therapy has proved unsuccessful. Yet, **children during their asylum period very seldom are referred to be assessed by specialists** such as: neuro-psychologists or child-psychiatrists. From a quick survey of child psychiatrists, we learned that in 2007 there were only 6 referrals of asylum-seeking children to private child-psychiatrists in the Copenhagen and Sealand Region. The child psychiatric ward in Hillerød recalls having three referrals in the last five years.

The waiting time-lapse and the narrow options of treatment children are exposed to, is related to cumbersome procedures of referral and lack of inter-service cooperation.

Funding of assessments and treatment for children during their asylum period requires either a psychologist's or a psychiatrist's written report sent to the Foreign Office after 5 preliminary consultations. The report has to contain a description of the problem, expected progress of the child with a particular treatment, and a prognosis about how long the treatment will take. The Foreign Service's staff, who usually have no medical qualifications, evaluate these reports and either grant or refuse health benefits for the children.

Because the Foreign Service operates with a concept of therapy on an individual basis, family interventions are very difficult to be funded. In this sense, other therapeutic options for the children are blocked by management's rigidity.

Psychological screening of all children during the first three months of asylum is funded by grants. Once this project is over, screening remains an unsure task.

Asylum-seeking parents and unaccompanied children lack professional counseling to make informed decisions about assessment and treatment for themselves and their children. Because legislation about asylum and health care crosses each other's path, for ex. the case of psychiatric reports supporting applications for humanitarian residence permit – is a neglected issue. There is a need to assist asylum seekers with personal asylum counseling.

9.2. General public acceptance / resistance about programs and costs dedicated to asylum seeking and refugee children

Except for voicing specific requirements such as: to be successful children have to learn Danish and drop their family's language and cultural practices to embrace the Danish, public opinion is not so much concerned about children to refugee families nor about expenses. Exceptionally, the "Recuperation Package" (May 2010) launched by the Danish government imposes restrictions on welfare benefits for refugees and immigrants, for example access to interpreters free of charge. (see p. 16)

From another angle successful educational carriers of second generation students, who perform brilliantly in final exams become headlights and are subject to encouragement.

The second generation's invisibility was unveiled by the issue of "arranged or forced marriages". The cultural practice of immigrant and refugee families of arranging marriages for their children falls into the category of unacceptable cultural practices in Denmark and it has been widely criticized by mass media and politicians. Legal actions to prevent arranged marriages resulted in laws that regulate the age of marriage to a foreigner "24-years-old-law" (2007).

To counteract parent's disappointment about their rejection of "arranged or forced marriages" some girls approach Child-Welfare Services to

be assisted. These girls need shelter and support to cope with death threats and estrangement from their family. Some of these girls assisted by Child-Welfare Services had to cut family bonds and get a new identity, while in other cases the Child-welfare service arranged “mediation” between the girl and her parents. Forced or arranged marriages are still topics of public opinion linked to disapproval and denunciation of this cultural practice as blocking integration.

The use of the head scarf for women has an explosive content because in Danish public opinion, it is a cultural practice that confirms “women’s repression by patriarchal practices”. By 2002-2003 the wave of discontent towards this practice became nasty and indeed blocked jobs for young women, who wore the head scarf. More and more young women started to wear the scarf using it as defiance and as a claim for freedom of dress and religion. Moreover, young Danish girls converted to Islam wear head scarf. To get hold of these young and efficient women, some enterprises, corporations, firms adapted their personnel policies to these girls’ attire, including a head scarf as part of the uniform dress code.

Once again the Danish public opinion was chocked by the riots youth to immigrant and refugee families provoked in 2008. In its aftermath a change of attitude about children to refugee and immigrant families took an amazing turn. Explanations about what went wrong span from failed integration policies for second generation to claims of close-the-borders-to-prospective-terrorists. The notion that integration policies for second generation had failed called for finding explanations and “culprits”. Public opinion did not favor rioting but understood that in an unequivocal way the second generation was sending a message: a protest against being excluded, stigmatized and discriminated. One explanation of the youth’s rage and violent expressions relies on the notion that the second generation was either trapped in their parents’ ambitions or their neglect. Parents’ ambitions pressed their children to succeed and collided with their child’s poor school or academic performance. Or else parents burdened by traumatization neglected their children, who lacked parental guidance and support. Other explanations blame integration policies that instead of integrating second generation, exclude them by shutting down educational and labour options for them.

According to studies on refugees and immigrants and their participation in educational activities, there is a mismatch between second generation’s skills and the competencies the Danish labour market demands. To obtain a successful integration into the Danish labour market requires among others, an upgrading of their skills in order to meet the market’s demands. There is a partial understanding that the second generation should be helped to achieve the skills and competencies the labour market demands. In order to develop individual qualifications in line with the labour market’s demands requires building up an interaction between educational activities in the educational system and the learning environment of enterprises and workplaces. It is precisely this interaction of “linking networks” what second generation usually lack and get excluded by.

Current educational solutions are engaged in programs such as “keep-your-students” and “individual mentor” to ensure among other, second generation to finish their vocational or professional studies. Young immigrants and refugees who have received vocational training or have a higher Danish education are offered some jobs, depending on the company’s personnel policies and engagement of instructors.

In 2009 public opinion was stirred by shooting episodes between ethnic Danish and immigrants’ gangs involved in criminal activities. During some months certain neighborhoods of Copenhagen were heavily patrolled and inhabitants were afraid of being caught in crossfire. The shootings definitely provoked a radical shift in the perception of the second generation.

Prone to generalization, public opinion associated the second generation involved in gang activity with organized criminality or worse, with terrorism. It is unclear if the shift of perception about second generation from “marginalized youth” to “prospective terrorists” is stable or temporary. Police’s efforts to control menacing gang activity doubled surveillance of young gang leaders and gang members as well as the general public. Focus on surveillance of youth activity worries some sectors of the Danish population who fear more restrictions to civil rights. Still, others feel more comfortable about sacrificing their rights for safety. Yet strong associations between terrorism and the second generation fuels fear and mistrust towards them. An emerging tendency to blame lenient immigration policies as the cause of prospective terrorism in Denmark serves the purpose to sharpen the close-the-borders-to-refugees-strategy.

Recently, focus on Danish policies towards protection of refugees turned to boiling point once more. Changes in immigration policies that favor labour immigration relinquishing protection of refugees were highlighted by Amnesty International’s annual report 2009. Amnesty International criticizes Denmark’s decision to rely on so-called ‘political assurances’ to determine whether it is safe to send refugee families with their children back to countries where their human rights are knot protected. Asylum seeking families from Iraq are currently awaiting deportation after being denied asylum.

Forced deportation meant that ‘at least 11 Iraqis were forcibly returned to Iraq, contrary to the recommendations of the UNHCR, the UN refugee agency’. Amnesty International added that ‘some asylum seekers who had been subjected to torture or other ill-treatment did not receive adequate medical treatment in Denmark’. (2)

In May 2009 the government of Denmark agreed with its counterpart in Iraq to deport 265 persons who found themselves in “expulsion phase 3” (see pp. 7-8). These asylum seekers received notification that they were due to be deported with the approval of Iraq. Some days later a group of these families, elders and singles sought refuge in a Danish church. Because these asylum seekers were experiencing a considerably protracted asylum period (6 – 10 years), their petition to the Danish authorities was to review their applications.

Public opinion became divided once more between those who meant taking refuge in a Christian church was a desperate strategy to be heard and

should be supported. On the other hand, there were political pressures favoring forced deportation.

In August at night a police force expelled all asylum seekers from the church and encountered resistance from a group of activists who were supporting asylum seekers mostly from Iraq. While most men among asylum seekers were detained, women and children as well as elders were left back to fend for themselves. Some returned to the Asylum Camps while others sought shelter and safety with people they knew. Between May and September most of the asylum seekers who found themselves in expulsion phase 3 were deported.

There is a general agreement that children to asylum seekers, who are in Denmark between 3 – 6 years, undoubtedly will have a better life in Denmark than in countries with civil unrest and armed conflicts.

9.3. Challenges and issues concerning the children's health-care and social welfare, education and leisure activities

Danish authorities should be aware of **structurally created health and social risk factors for children due to protracted asylum phase**. Research shows the impact of extensive long periods in the asylum camps with burdening settings, lack of social contact with "other children" from the Danish population, relocations in different asylum camps, idle and meaningless life in the camps, their parents' hardships and psychological distress or disturbances etc. are detrimental to the children's mental health and are responsible for the children's mounting difficulties to carry on with their life.

All refugee children affected to some extent by the experiences of terror, persecution, war, etc. in their home countries, flight from home to an unknown place and their life during asylum period should be assessed and treated according to professional standards. Studies of traumatized children have shown that children's symptoms seem to have a "latency period", before they show signs of intellectual, social and emotional distress. Unfortunately the demands for treating children in general and specifically children to refugees exceed the capacity of child-welfare services and child psychiatric centers.

Many humanitarian organizations are observant of asylum conditions and policies and have issued protests, for ex. Danish Doctor's Association, Amnesty Denmark – doctor's group (2), Save the Children and Danish Refugee Council. (8)

Children to refugee parents, who are diagnosed a psychiatric illness either due to traumatization or other reasons, should receive assistance and support. Studies about children to parents with traumatization and psychiatric disturbances show that children suffer emotional and social consequences. Preventive measures should be taken about these health-risk-factors for the children.

The economical situation of many refugee families is unacceptable. Refugees who live on "start help" or "reduced help" cannot support themselves leading to unprecedented levels of poverty and thus

creating a greater risk of social marginalization for their children. These families suffer from legally prescribed discriminative practices and have no rights to apply for extra-benefits. Children to these families grow up living off precarious economical benefits for years and are at risk of becoming frustrated youths daring the Danish establishment.

Elder children should be granted the legal right to seek asylum independent of his/her parents' asylum case – just like in Canada.

Preventive programs about radicalization of youth associated to ethnic minorities admit a certain dire connection between parent's traumatization and gang organization as well as criminality. This issue should be a subject of research.

An endemic problem is lack of professional training to qualify assessments and treatments for refugee children (and immigrant children) in municipalities' Pedagogical-psychological Units (PPR), Health Clinics as well as psychiatric services. Also professionals in Child-Welfare Services, schools and day care centers often do not have relevant qualifications to assist and support special needs of refugee children. It is necessary that emphasis on **professionalization of the services** gets high priority. Relevant and professional training is required for its personnel to work with refugee (or immigrant) families and their children clearing the way from ethnocentric prejudices, myths and negative representations that block, blind or obstruct otherwise dedicated work.

Capacity building in the public and private health sector should be able to absorb demands from refugees for specialized rehabilitation. Long waiting lists in Specialized Rehabilitation Centers exert added strains for traumatized adult refugees and children, who have to wait between 3 – 6 months or 2 – 3 years for a treatment. It is certainly a discouraging prospect for children's mental health and welfare.

There is an imperative need to **promote inter-services cooperation** within a given municipality or across municipalities and regional services to be able to provide efficient support for not only refugee children but for all children. There are many gaps of information processing and cooperative understanding between services, a matter which does not promote continuity either for the child's health monitoring or preventive support.

There is a need for stating policies and requesting scientific evidence about current **procedures of reception of children** to asylum seeking and refugee families.

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Appendix index

Appendix 1

Total children to immigrants and descendants in Denmark[5]

	2006	2007	2008	2009	2010[6]
Immigrants from western countries	6084	6413	7127	8640	9753
Immigrants from non-western countries	25780	23571	21842	20314	18400
Total	*31864*	*29984*	*28969*	*28954*	*28153*
Descendants from western countries	6958	7197	7379	7900	9063
Descendants from non-western countries	79588	80975	82583	83874	85082
Total	*86546*	*88172*	*89962*	*91774*	*94145*

[5] www.statistikbanken.dk/Befolkning og valg/Folketal efter 1. jan.2009, herkomst, område, alder og tid

[6] By 1. October 2010

Appendix 2

Unaccompanied asylum-seeking children 2004-2009[7]

Nationality	2004	2005	2006	2007	2008	2009
Afghanistan	22	11	17	39	168	386
Algeria	3	3	3	0	6	8
Iraq	8	7	51	31	67	30
Iran	6	5	5	3	20	22
Somalia	12	7	3	3	5	26
Syria	0	2	1	0	0	11
Others	77	74	27	17	36	46
Total	128	109	107	93	302	529
% of all asylumseekers	4%	5%	5%	5%	13%	14%

[7] Tal og fakta på udlændingeområdet 2009 (2010): Udlændinge Service, Ministeriet for flygtninge, indvandrere og integration, s. 43.

Appendix 3

Unaccompanied asylum seeking minors, distributed by Age and Gender 2002-2007[8]

	Year	**2002**		**2003**		**2004**		**2005**		**2006**		**2007**	
Age	Gender	Num.	*Pct.*	Num.	*Pct.*	Num.	*Pct.*	Num.	*Pct.*	Num.	*Pct.*	Num.	*Pct.*
0-11 Years	Boys	6	4,4%	7	4,4%	7	5,5%	3	2,8%	3	2,8%	2	2,2%
	Girl	2	1,5%	2	1,3%	3	2,3%	2	1,8%	1	0,9%	1	1,0%
	Total	8	5,8%	9	5,7%	10	7,8%	5	4,6%	4	3,7%	3	3,2%
12-14 Years	Boys	8	5,8%	17	10,7%	17	13,3%	17	15,6%	17	15,9%	7	7,6%
	Girls	6	4,4%	3	1,9%	6	4,7%	8	7,3%	3	2,8%	0	0,0%
	Total	14	10,2%	20	12,6%	23	18,0%	25	22,9%	20	18,7%	7	7,6%
15-17 Years	Boys	101	73,7%	104	65,4%	76	59,4%	65	59,6%	76	71,0%	80	86,0%
	Girls	14	10,2%	26	16,4%	19	14,8%	14	12,9%	7	6,6%	3	3,2%
	Total	115	83,9%	130	81,8%	35	74,2%	79	72,5%	83	77,6%	83	89,2%
Total		**137**	**100%**	**159**	**100%**	**128**	**100%**	**109**	**100%**	**107**	**100%**	**93**	**100%**

[8] Tal og fakta på udlændingeområdet 2008 (2009): Udlændingeservice. Ministeriet for Flygtninge, Indvandrere og Integration.

Appendix 4

Immigration to Denmark 2002 - 2009

	2002	2003	2004	2005	2006	2007	2008	2009
Population 1. january (i 1000)[9]	**5.368**	**5.384**	**5.398**	**5.411**	**5.427**	**5.447**	**5.476**	**5.511**
Immigrants from abroad	**52.77**	**49.754**	**49.860**	**52.458**	**56.750**	**64.656**	**72.749**	**67.161**
Brutto asylum seekers [10]	**6.068**	**4.593**	**3.235**	**2.281**	**1.960**	**2.246**	**2.409**	**3855**
EU countries	171	279	119	76	43	47	21	50
Europa (ekskl. EU-countries)	1.944	1.666	1.395	793	523	345	499	809
Afrika	867	783	530	377	260	176	296	545
North America	10	2	0	0	0	1	1	2
South- and Middel America	16	45	13	8	6	3	8	18
Asian	2.859	1.627	1.008	913	1.050	1.614	1.479	2337
Oceanian	0	1	0	1	0	0	0	0
Stateloose	199	188	168	107	78	59	104	94
Undetermined	2	2	2	6	0	1	1	0

[9] www.statistikbanken.dk/Befolkning og valg/asylansøgere efter asyltype, statsborgerskab og tid

[10] www.statistikbanken.dk/Befolkning og valg/asylansøgere efter asyltype, statsborgerskab og tid

Appendix 5.

Asylum seekers 2002-2009 with countries of origin[11]

	2002	2003	2004	2005	2006	2007	2008	2009
Albanien	75	51	26	21	21	6	15	12
Armenien	37	23	29	19	17	4	12	17
Aserbajdsjan	29	16	30	24	12	20	23	14
Belgien	0	0	0	3	0	0	0	0
Bosnien-Hercegovina	186	231	102	49	39	41	26	37
Bulgarien	37	134	32	28	11	10	2	26
Cypern	0	0	0	0	0	0	0	1
Estland	1	4	1	0	0	0	0	1
Finland	0	1	0	0	2	0	0	0
Frankrig	1	0	0	2	0	0	0	1
Georgien	44	29	32	10	19	6	26	17
Holland	0	1	0	0	0	8	1	0
Hviderusland	30	28	18	24	4	3	6	8
Island	0	0	0	0	0	0	1	0
Kasakhstan	10	14	8	1	4	3	4	4
Kirgisistan	3	1	6	5	1	0	5	0
Kosovo	0	0	0	0	0	47	57	124
Kroatien	20	6	21	6	3	1	11	6
Letland	3	9	10	4	4	0	2	0
Litauen	8	12	18	15	0	4	4	0
Makedonien	92	80	50	39	14	13	15	15
Moldova	7	36	7	24	4	2	1	11
Montenegro	0	0	0	0	0	5	3	2
Norge	0	0	0	1	0	0	0	0
Polen	15	16	4	3	7	1	2	1
Rumænien	21	38	31	8	14	5	5	17
Rusland	198	269	163	119	61	115	184	341
Serbien	0	0	0	0	0	44	61	151
Serbien og Montenegro	1030	750	784	383	274	0	0	0
Slovakiet	35	32	17	0	3	15	0	2
Slovenien	1	3	3	0	0	1	0	1
Sverige	3	1	0	0	1	0	0	0
Tadsjikistan	3	1	1	0	0	0	0	3
Tjekkiet	31	23	0	13	1	0	1	0
Turkmenistan	0	0	2	2	3	1	0	1
Tyrkiet	111	108	84	47	40	24	39	29
Tyskland	2	2	0	0	0	0	0	0
Ukraine	42	18	21	9	3	5	7	9
Ungarn	13	3	3	0	0	3	4	0

[11] www.statistikbanken.dk/Befolkning og valg/Asylansøger efter statsborgerskab og tid

Usbekistan	27	5	11	10	4	5	3	8
Algeriet	97	62	50	46	15	17	38	46
Angola	11	6	1	2	2	1	1	0
Benin	2	2	1	1	0	2	0	0
Burkina Faso	1	2	1	3	2	0	0	2
Burundi	37	35	27	17	3	3	3	2
Cameroun	17	8	6	12	10	4	7	3
Congo	8	3	4	2	1	0	4	4
Djibouti	1	0	0	1	0	0	0	0
Egypten	9	9	5	6	1	2	5	6
Elfenbenskysten	5	10	5	9	1	3	4	6
Eritrea	3	5	18	8	5	6	15	37
Etiopien	7	6	6	15	9	3	5	6
Gabon	0	0	0	1	1	0	0	0
Gambia	16	8	3	1	6	6	0	5
Ghana	3	9	7	6	8	6	17	16
Guinea	18	23	16	4	4	4	1	9
Guinea-Bissau	0	3	8	2	2	2	0	7
Kenya	5	0	2	1	4	0	4	4
Liberia	6	17	11	3	11	1	2	5
Libyen	28	14	16	20	11	4	6	18
Malawi	0	0	0	0	1	0	0	0
Mali	2	0	1	1	1	0	0	2
Marokko	20	18	17	14	15	7	19	31
Mauretanien	0	1	2	0	0	2	1	1
Niger	9	2	3	2	1	1	1	3
Nigeria	62	61	89	55	52	22	30	54
Rwanda	16	22	8	2	4	10	2	5
Senegal	1	0	4	2	3	1	2	1
Sierra Leone	9	13	11	6	3	3	6	1
Somalia	391	370	154	81	58	37	66	179
Sudan	41	34	17	21	5	9	10	26
Swaziland	0	0	0	0	0	0	0	1
Sydafrika	0	1	0	1	0	0	0	0
Tanzania	2	2	3	1	3	0	2	0
Tchad	0	2	0	0	0	1	0	1
Togo	7	2	0	3	2	0	3	1
Tunesien	11	7	11	4	2	6	11	9
Uganda	7	6	5	13	4	6	17	19
Congo, Demokratiske Republik (tidl. Zaire)	12	18	13	10	7	3	9	25
Zambia	0	1	0	0	2	0	0	1
Zimbabwe	3	1	2	1	1	4	5	9
Ækvatorialguinea	0	0	3	0	0	0	0	0
Canada	6	0	0	0	0	0	1	1
USA	4	2	0	0	0	1	0	1
Bolivia	0	1	0	4	0	0	2	0
Brasilien	0	0	4	0	1	0	1	0
Chile	0	3	0	0	0	1	0	1
Colombia	5	1	1	0	2	0	0	3
Cuba	1	3	3	1	2	0	2	1

Dominikanske Republik	0	0	0	0	0	0	0	2
Ecuador	1	28	3	0	1	0	0	2
Guatemala	3	6	0	0	0	0	0	2
Haiti	0	0	1	0	0	1	2	4
Honduras	1	1	0	0	0	0	0	0
Jamaica	0	0	0	1	0	0	0	0
Mexico	0	1	0	1	0	0	0	0
Nicaragua	1	0	0	0	0	0	0	0
Peru	2	1	0	1	0	0	0	1
Uruguay	1	0	0	0	0	0	0	0
Venezuela	1	0	1	0	0	1	1	2
Afghanistan	1186	664	285	182	127	144	424	1059
Bangladesh	12	24	21	16	14	6	14	18
Bhutan	0	0	0	1	0	3	3	3
Cambodja	2	0	0	1	1	1	0	0
Filippinerne	0	1	0	1	0	0	0	0
Indien	96	52	39	72	84	56	37	33
Indonesien	0	1	2	0	0	0	0	0
Irak	1045	442	217	264	519	1071	562	309
Iran	178	158	140	123	89	109	202	334
Israel	6	1	6	0	6	2	2	1
Japan	0	0	3	0	0	0	0	0
Jordan	15	8	7	2	2	4	7	5
Kina	50	76	64	71	35	41	19	21
Kuwait	1	1	1	1	0	0	1	2
Libanon	46	26	29	27	26	18	11	16
Malaysia	0	0	2	3	0	0	0	0
Mongoliet	31	7	9	10	8	10	6	5
Myanmar (tidl. Burma)	5	3	1	9	8	5	9	16
Nepal	20	17	6	10	5	4	5	3
Nordkorea	1	0	1	0	1	0	2	2
Pakistan	63	36	81	39	31	17	14	49
Saudi-Arabien	0	0	1	0	0	0	0	0
Sri Lanka	38	21	18	22	31	42	53	62
Syrien	31	56	56	45	55	74	107	383
Thailand	0	2	1	0	0	0	0	0
Vietnam	28	29	15	14	6	6	1	14
Yemen demo. folkerep	5	2	3	0	2	1	0	2
Australien	0	0	0	1	0	0	0	0
New Zealand	0	1	0	0	0	0	0	0
Statsløs	199	188	168	107	78	59	104	94
Uoplyst	2	2	2	6	0	1	1	0

Appendix 6

Asylum seekers awaiting deportation ultimo years 2004-2009[12]

Nationalities	2004	2005	2006	2007	2008	2009	Share2009
Iraq	657	586	584	408	294	94	18%
Iran	68	64	61	64	67	72	14%
Somalia	66	75	71	60	47	46	9%
Afghanistan	160	27	22	20	19	40	8%
Serbia & Montenegro	576	388	160	31	28	35	7%
Russia	30	12	19	6	29	30	6%
Azerbaijan	30	17	12	9	18	20	4%
Stateless Palestinians	135	88	54	39	19	16	3%
Bosnia-Herzegovina	64	21	14	1	3	9	2%
Nigeria	6	6	7	4	2	8	2%
Turkey	11	7	9	4	10	8	2%
Syria	25	19	19	8	7	7	1%
Others	313	158	128	100	122	125	24%
Total	**2.141**	**1.468**	**1.160**	**754**	**665**	**510**	**100%**

Ad Serbia and Montenegro: of the 35 persons awaiting deportation ultimo 2009, 21 was from Serbia and 14 from Kosovo

[12] Tal og fakta på udlændingeområdet 2009 (2010): Udlændinge Service, Ministeriet for flygtninge, indvandrere og integration, s. 46.

Appendix 7

Billeting informations 2004-2009*[13]

Category (2009-prizes excl.VAT)	2004	2005	2006	2007	2008	2009
Consumption Total (mill kr.)	611,2	475,0	394,6	419,5	360,4	516,2
Yearly average occupation (persons)	4.286	2.950	2.161	1.771	1.707	2.368
Yearly unit prize per. Person (kr.)	142.600	161.017	182.618	236.827	213.500	218.015
*-of this, operation of billeting system***	*44.965*	*50.894*	*49.457*	*90.979*	*69.337*	*69.159*
*-of this, cash payments ****	*22.287*	*21.668*	*21.074*	*21.729*	*23.391*	*23.573*
*-of this, billeting of asylumseekers*****	*75.348*	*88.456*	*112.087*	*124.119*	*120.772*	*125.283*
Number of running centers	16	11	9	9	7	17
Number of billeted (ultimo year)	3.736	2.465	1.934	1.802	1.832	3.121

* 2009 numbers are taken from *Årsrapporten 2009*

** amounts to 31,7% of total expenses in 2009. Includes rents, maintenance of buildings, reception etc.

*** amounts to 10,8% of total expenses in 2009. Includes basic -, caregiver - and supplementary allowances.

**** amounts to 57,5% of total expenses in 2009. Includes social benefits and health services.

[13] Tal og fakta på udlændingeområdet 2009 (2010): Udlændinge Service, Ministeriet for flygtninge, indvandrere og integration, s. 45.

Appendix 8

Sundhedsplejerskens undersøgelse af børn ved ankomsten
Screening

Sygdomme	ja	nej	ved ikke	Bemærkninger
Allergi				
Aktuel medicin				
Misbrug				
Tidligere sygdomme				
Epidemiske / tropesygdomme				
Hepatitis a/b				
TB				
Henvist til blodprøve mht hepatis B vacc.				
Andet				

Har barnet aktuelt eller tidligere haft problemer med	ja	nej		Bemærkninger
at sove				
at spise				
Synet				
Hørelsen				
Ufrivillig vandladning				
Ufrivillig afføring				
Urinvejsinfektion				
Hovedpine / tandpine				
Motorikken				
Andet				

Separation	ja	nej	hvornår	Hvor længe
Far				
Mor				
Søskende				

Tab	ja	nej	hvornår	Bemærkninger
Far				
Mor				
Søskende				
Andre				

Vold	ja	nej	ved ikke	Bemærkninger
Barnet har været vidne til vold				
Barnet har været udsat for vold				

Appendix 9 Rehabilitation centers and waiting lists

DANSK FLYGTNINGE HJÆLP

Oversigt over ventetider på de specialiserede tværfaglige behandlingsinstitutioner for flygtninge med traumer

Alle oplysninger i skemaet er opgivet af de pågældende institutioner selv. På institutionernes hjemmesider og på traume.dk er der informationer om de forskellige institutioners behandlingstilbud.

Institutionens navn	1. marts 2009 a. anslået ventetid b. personer på venteliste	1. marts 2010 a. anslået ventetid b. personer på venteliste	Finansiering
Region Hovedstaden			
Dansk Røde Kors' Psykotraumecenter, København www.psykotraumecenter.drk.dk	a. Ingen b. Ingen	a. Ingen b. Ingen	Kommunal
Etnisk Rådgivningscenter NOOR, København www.noor.dk	Op til 6 måneders ventetid på enkelte behandlingstyper	Ingen ventetid på at starte i et forløb. Undervejs i forløbet kan der opstå ventetid på visse behandlingstyper (især psykolog og kropsbehandling) på mellem 3 måneder og 1 år.	Kommunal
OASIS, København www.oasis-rehab.dk	a. 8-10 måneder b. 125 personer	Visitation: a. 6-12 uger b. 35 personer 41 personer er under visitation Behandling: a. 8-12 måneder b. 32 personer	Sundhedsloven

Psykiatrisk traumeklinik for flygtninge, Gentofte www.psykiatri-regionh.dk/traumeklinik	a. 3-4 måneder b. 50-60 personer	a. Ingen b. Ingen	Sundhedsloven
RCT, København www.rct.dk	a. 1-1½ år b. 106 personer	Ekstern venteliste: a. 9-14 måneder til behandling b. 90 personer Assesment venteliste: a. 4-9 måneder til behandling b. 50 personer Intern venteliste: a. 0-4 måneder til behandling b. 23 personer	Sundhedsloven
Region Sjælland			
Klinik for Traumatiserede Flygtninge, Vordingborg www.regionsjaelland.dk	a. 9-12 måneder b. 64 personer	b. 55 personer	Sundhedsloven
Klinik for Traumatiserede Flygtninge, Roskilde www.regionsjaelland.dk	a. 8-10 måneder b. 25-30 personer	b. 46 personer	Sundhedsloven
Region Syddanmark			
CETT, Vejle www.cett.dk	Visitation: a. 4 måneder b. 33 personer Individuel behandling: a. 2-2½ år b. 54 personer Udgående behandling i eget hjem: a. 12 måneder	20 personer venter på udredning CETT forventer, at de i løbet af 2010 kan leve op til kravene i den udvidede behandlingsret for de fleste patienters vedkommende, dvs. at behandlingen påbegyndes senest otte uger efter, henvisningen er modtaget.	Sundhedsloven

Psykiatrisk traumeklinik for flygtninge, Gentofte www.psykiatri-regionh.dk/traumeklinik	a. 3-4 måneder b. 50-60 personer	a. Ingen b. Ingen	Sundhedsloven
RCT, København www.rct.dk	a. 1-1½ år b. 106 personer	Ekstern venteliste: a. 9-14 måneder til behandling b. 90 personer Assesment venteliste: a. 4-9 måneder til behandling b. 50 personer Intern venteliste: a. 0-4 måneder til behandling b. 23 personer	Sundhedsloven
Region Sjælland			
Klinik for Traumatiserede Flygtninge, Vordingborg www.regionsjaelland.dk	a. 9-12 måneder b. 64 personer	b. 55 personer	Sundhedsloven
Klinik for Traumatiserede Flygtninge, Roskilde www.regionsjaelland.dk	a. 8-10 måneder b. 25-30 personer	b. 46 personer	Sundhedsloven
Region Syddanmark			
CETT, Vejle www.cett.dk	Visitation: a. 4 måneder b. 33 personer Individuel behandling: a. 2-2½ år b. 54 personer Udgående behandling i eget hjem: a. 12 måneder	20 personer venter på udredning CETT forventer, at de i løbet af 2010 kan leve op til kravene i den udvidede behandlingsret for de fleste patienters vedkommende, dvs. at behandlingen påbegyndes senest otte uger efter, henvisningen er modtaget.	Sundhedsloven

	b. 31 personer		
RCT Fyn, Odense www.rctfyn.dk	Behandlingstilbud uden værksted: a. Knapt 2 år b. 76 personer Behandlingstilbud med værksted a. 1-2 måneder b. 4 personer	a. Gennemsnitligt 15 måneder (ventetiden afhænger af det tilbud, der visiteres til) b. 51 personer	Sundhedsloven Der er kommunal medfinansiering på centrets dagtilbud med værksted.
RCT-Jylland, Haderslev samt projekt i Sønderborg www.rct-jylland.dk	a. 1½-2 år b. 170 personer	a. 1½ år b. 150 personer	Sundhedsloven
Region Midtjylland			
Klinik for Traumatiserede Flygtninge, Århus samt sats-teams i Randers og Rønde www.kftf.dk	a. 10-12 måneder b. 113 personer	Århus Forundersøgelse: b. 33 personer Behandling: a. 6 måneder b. 38 personer Randers Forundersøgelse: b. 9 personer Behandling: a. 6 måneder b. 12 personer Rønde Forundersøgelse: b. 9 personer Behandling: a. 11 måneder b. 11 personer	Sundhedsloven

	b. 31 personer		
RCT Fyn, Odense www.rctfyn.dk	Behandlingstilbud uden værksted: a. Knapt 2 år b. 76 personer Behandlingstilbud med værksted a. 1-2 måneder b. 4 personer	a. Gennemsnitligt 15 måneder (ventetiden afhænger af det tilbud, der visiteres til) b. 51 personer	Sundhedsloven Der er kommunal medfinansiering på centrets dagtilbud med værksted.
RCT-Jylland, Haderslev samt projekt i Sønderborg www.rct-jylland.dk	a. 1½-2 år b. 170 personer	a. 1½ år b. 150 personer	Sundhedsloven
Region Midtjylland			
Klinik for Traumatiserede Flygtninge, Århus samt sats-teams i Randers og Rønde www.kftf.dk	a. 10-12 måneder b. 113 personer	Århus Forundersøgelse: b. 33 personer Behandling: a. 6 måneder b. 38 personer Randers Forundersøgelse: b. 9 personer Behandling: a. 6 måneder b. 12 personer Rønde Forundersøgelse: b. 9 personer Behandling: a. 11 måneder b. 11 personer	Sundhedsloven

Klinik for Traumatiserede Flygtninge, Horsens www.kftf.dk	a. 8 måneder b. 38 personer	Forundersøgelse: b. 10 personer Behandling a. 4-6 måneder b. 22 personer	Sundhedsloven
Klinik for Traumatiserede Flygtninge, Holstebro www.rm.dk	a. 5½ måned b. 52 personer	Forundersøgelse: b. 15 personer Behandling: a. 6 måneder b. 57 personer	Sundhedsloven
Region Nordjylland			
Rehabiliteringscenter for Flygtninge, Aalborg www.flygtning.rn.dk	Behandling under Sundhedsloven: a. 1 år b. 51 personer Indtægtsgivende ydelse: a. 6 måneder b. 13 personer	Behandling under Sundhedsloven: a. 1 år b. 60 personer Indtægtsgivende ydelse: a. 6 måneder b. 13 personer	Sundhedsloven Kommunal

Appendix 10[14]

Cost-benefit calculations for asylum seekers

Examples of cash benefits to asylum seekers during the **preliminary (1. Phase)** of case processing, or to asylum seekers who have received a **final refusal of asylum (3. Phase)**, and who receive additional maintenance:

Ex 1. Family with two adults and two children who lives at an asylum centre without provision of meals: 2,921.80 kr. a fortnight.

Ex. 2. Single adult without children who lives at an asylum centre without provision of meals: 802.06 kr. a fortnight.

Examples of cash benefits to asylum seekers whose cases are being handled after the 'normal procedure':

Ex. 3. Family with two adults and two children who lives at an asylum centre without provision of meals: 4,067.56 kr. a fortnight.

Ex. 4. Single adult without children who lives at an asylum centre without provision of meals: 1,088.50 kr. a fortnight.

Examples of cash benefits to asylum seekers placed on the 'food allowance' programme (no supplementary allowances):

Ex. 5. Family with two adults and two children placed on the 'food allowance' programme and who lives at an asylum centre without provision of meals: 2,463.16 kr. a fortnight.

Ex. 6. Single adult without children placed on the 'food allowance' programme and who lives at an asylum centre without provision of meals: 687.40 kr. a fortnight.

[14] http://www.nyidanmark.dk/da-dk/Ophold/asyl/asyl.htm (June 2010)