



Submission from the

Forum of Australian Services for Survivors of

Torture and Trauma

to the Australian Human Rights Commission

National Inquiry Into Children in Immigration

Detention

13 June 2014

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FORUM OF AUSTRALIAN SERVICES TO SURVIVORS OF TORTURE AND TRAUMA

SUBMISSION TO THE AUSTRALIAN HUMAN RIGHTS COMMISSION NATIONAL INQUIRY INTO CHILDREN IN IMMIGRATION DETENTION

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CHILDREN IN IMMIGRATION DETENTION 2014**

The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) appreciates the opportunity to provide a submission to the inquiry of the Australian Human Rights Commission into children in immigration detention.

FASSTT is a network of agencies in each State and the mainland Territories that provide specialist torture and trauma rehabilitation services to people from refugee and refugee-like backgrounds. FASSTT agencies are contracted by the Commonwealth Department of Health to provide services under the Program of Assistance for Survivors of Torture and Trauma. They also secure additional funds from governmental, philanthropic and private sources to undertake a range of other activities. The range of services and activities include:

- Counselling
- Advocacy and referrals to mainstream health and related services
- Training for mainstream health and other service providers
- Community development and capacity building activities
- Support of rural and regional services in areas where refugees live
- Research

FASSTT agencies work with approximately 14,000 clients in total each year of whom many are children i.e. under 18 years of age. Some are 'unaccompanied minors' (arrived in Australia without a natural parent or a relative aged 21 years or older); some are members of families that are receiving our services as a unit or they have families in Australia but are clients in their own right.

The information and analysis contained in this submission is based on FASSTT agencies' work over the last five years providing client services to several hundred children who are or were in immigration detention facilities in Australia and in facilities managed on behalf of the Australian Government in Nauru and Papua New Guinea. All of the children and adults whose cases are cited in the submission are or were clients.

To assist the work of the Commission we also append a literature review on the impact of trauma on children under 5 years of age and the need for early intervention, prepared by FASSTT member agency the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors.

While the submission is based on the experiences of our clients, it is quite apparent that the issues of concern identified may affect all children in immigration detention and not only children seen by FASSTT agencies. The evidence is compelling that 'held' immigration detention, particularly when it is prolonged, may cause serious harm to children.

FASSTT agencies made submissions to the Human Rights and Equal Opportunity Commission National Inquiry into Children in Immigration Detention that was completed in 2004.¹ As detailed in the present submission, key concerns described

¹ Submission to the HREOC Inquiry into Children in Immigration Detention: *Trauma changes adults but forms children – Protecting and healing child asylum seekers and refugees*, Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS NSW) and Friends of STARTTS (FOS), May 2002; Submission to the National Inquiry into Children in Immigration Detention from the Victorian Foundation for Survivors of Torture (VFST), Submission No.184,

in those submissions about adverse impacts of immigration detention on children are present today.

Pre-arrival experiences

Many children who are our clients experienced traumatic events in their countries of origin, in countries where they and their families sought shelter and in transit to Australia. This is starkly illustrated by the data of one agency with respect to clients aged 0-17 in detention seen during 2012-13.² The children's experiences included:

- Severe beating
- Rape
- Coming under combat fire
- Living in hiding
- Internal displacement
- Lack of food, water or shelter
- Killing or disappearance of close family members
- Forced separation from family
- Kidnapping
- Witnessing people killed or subjected to physical violence

A 17 year old unaccompanied minor had a significant history of trauma including the death of his father and uncle as a result of suicide attacks. He spoke about numerous atrocities that he witnessed from a young age, including two suicide attacks (one in front of his home and another in front of his school). At age 10, he witnessed a person being beheaded and he described the devastating effects that this had on him including repeated nightmares and screaming in his sleep and extreme fear that prevented him from leaving his house for a month following the incident. He also spoke about witnessing people being killed and dead bodies being eaten by dogs in front of his house.

Many of the children arrived in Australia with physical and psychological conditions that were clearly linked to their pre-arrival experiences and circumstances. Such conditions included post-traumatic stress disorder, separation anxiety, poor nutrition and illnesses acquired in refugee camps including Hepatitis B and gastrointestinal parasites.

A girl who was 4 years old when in detention fell off the boat on the way to Australia. She developed significant post-traumatic symptoms relating to the boat journey, including hypersensitivity to

<https://www.humanrights.gov.au/publications/commission-website-national-inquiry-children-immigration-detention-193>.

² Victorian Foundation for Survivors of Torture Inc., *Annual Report 2012-2013*, page 7. Many of these clients were in community detention at the time of being clients but all had been in 'held' detention in Australia for some period.

touch, and even two years after the boat journey would scream and tear at her clothes if they were wet. She experienced ongoing nightmares, fears, poor eating and sleeping patterns and continues to go to her mother's breast for security and comfort even though she is now 7 years old. She displayed aggressive behaviour, particularly towards her older brother who had an emotional breakdown after she fell off the boat. He also continued to suffer from post-traumatic symptoms from the time of the boat journey.

Children referred to FASSTT agencies

Children are referred to FASSTT agencies for assessment and assistance if they manifest or voice difficulties which are or may be associated with traumatic experiences of the kind identified in the preceding section. Referrals are made by the health provider in detention, International Health and Medical Services (IHMS), or by service providers, schools, GPs and other health services.

Among younger children, common symptoms include difficulty settling to sleep; sleep disrupted by nightmares; poor appetite; relapse to bed wetting; language regression and selective mutism (unable or unwilling to speak in certain situations not caused by physical disability); 'dysregulation' in behaviour such as tantrums, aggression and crying for long periods; severe distress when separated from family members; unexplained screaming; and significant developmental delays in various areas of functioning (such as social and emotional functioning, communication, learning ability, sensory processing and motor planning and coordination).

A 4 year old boy, who arrived in Australia with his mother and infant sibling, was detained for 8-9 months in four different locations. The child had experienced the disappearance of his father (presumed dead), had lived in hiding for sometime and his mother had been severely beaten during her pregnancy with his sibling and partially paralysed for two weeks following the birth. He presented with symptoms related to his traumatic experiences, including eating problems, nightmares, sleep disturbance, bed wetting, over sensitivity to sense of movement, fear of heights, severe dysregulation, separation anxiety, withdrawal from others and language and communication delays. His mother also suffered from problems with her physical and mental health, was preoccupied with settlement issues and had difficulty playing with the child.

Older children and adolescents present similar symptoms such as problems with sleeping, nightmares, poor eating or ongoing aggressive behaviour. They experience intrusive and distressing thoughts relating to traumatic memories. They express and exhibit feelings of profound hopelessness, low self-esteem, helplessness and suicidal ideation, and may physically harm themselves or attempt suicide.

A 16 year old unaccompanied minor described a number of symptoms that interfere with his daily functioning, including sleep disturbance, poor appetite, low energy, impaired concentration,

feelings of irritability and anger, sadness and feelings of isolation and despondency. He also spoke of physical pain and in his neck, chest, arms, legs and shoulders. He said his greatest worry was his own capacity to keep coping with the uncertainty of his situation, concern for the well-being of his family and intrusive thoughts related to traumatic memories. He described how at times he found himself in a daze and sometimes feared that he was going mad.

Many children manifest psychological stress in the form of physical problems such as stomach pain, ulcers and muscle tension. Young clients who are separated from family and close friends commonly manifest behavioural, emotional and physical signs and symptoms. In severe instances, it may adversely affect the child's ongoing capacity to form reciprocal emotional relationships and can be linked to disruptions in personality development.

Impact of immigration detention

Whether in the community or in immigration detention, asylum seekers generally experience significant adverse effects associated with their pre-arrival history, the loss of loved ones, prolonged separation from families and the length and uncertainty of the refugee status determination process.

However, evidence from our work highlights that held immigration detention exacerbates the effects of previous traumatic experiences, hinders the capacity to effectively manage those effects and can create new difficulties. This is the case for both adults and children, and for family units.

The following sections describe the main elements of the detention environment and regime that we have observed as potentially injurious to children, having the greatest impact on their psychosocial functioning. They are:

- Deprivation of freedom
- Fear for personal safety
- Witnessing of violence and self-harm by others in detention
- Adverse effects on family functioning
- Lack of meaningful and developmentally suitable activities
- Institutionalisation
- Length and uncertainty of detention

The submission is concerned with aspects of immigration detention in 'held' or secure facilities (as distinct from community detention) that may impact on children in any location. We do not describe issues of concern relating to any specific facility arising from factors such as its location (e.g. stressful climatic conditions; remoteness from services that readily available in areas with population apart from those connected to the detention facility), poor quality of shelter or the conduct of individual staff members.

Deprivation of freedom

Children commonly express a strong sense of injustice or shame about being treated as if they have been convicted of committing a criminal offence and sentenced to imprisonment. However good the quality of the physical conditions and activities in some facilities, detention is experienced as prison-like because those detained are disempowered, unable to leave without being escorted for scheduled events, constantly monitored and their daily activities are subject to rigid routines. In the words of one young client, “I am a prisoner here without a crime”.

A family with a 2 year old and a 10 year old was detained for 12 moths while other families in the same detention centre were released after shorter periods. The toddler displayed symptoms of increased emotional distress (e.g. excessive crying, tantrums and difficulty soothing self) and the older child developed an increased sense of being faulty or not good enough, often expressing concern that “they must have done something really bad to have been treated like this”. This has led to feelings of guilt, shame and self loathing in the father, who blames himself for putting the family through such an experience. His mental health has deteriorated, affecting his ability to engage actively with his children, which further impacts on their development.

Immigration detention is also experienced as punitive and difficult because of its apparent arbitrariness. Children are not told how long they will be detained; they are bewildered when others who may have been detained for less time are released into the community, without explanation. Releases and transfers disrupt friendships and support networks.

An unaccompanied minor watched many detainees being released during his time in detention as he continued to await a decision on his application. As a result, he showed increasing anger, irritability, agitation and distrust of authority. His mood deteriorated and he had a growing sense of hopelessness and helplessness, loss of interest in activities, loss of appetite and increased sleep disturbance. He spoke constantly about the unfairness of receiving no feedback about his application while many who arrived after him were released.

Many unaccompanied minors feel unable to disclose to family overseas that they are detained, feeling shame about their circumstances and fearing that their families will assume that they had done something wrong and be highly anxious about them. A number of these clients have made the painful decision to cease contact with their families while they are in detention, exacerbating difficulties arising from physical separation.

Some of the children who attend local schools report being bullied and stigmatised because they are escorted by guards and that other children have asked them whether they have committed a crime.

The sense that they have been punished for doing something wrong can significantly undermine children's self-confidence and sense of worth, affecting their ability to function well and relate to others well after they are released into the community.

A 17 year old unaccompanied minor has such strong feelings of shame and humiliation that he is too ashamed to admit to his peers at school that he has been re-detained and is living in detention.

Fear for personal safety

Children report fears for their personal safety both from security personnel and other detainees.

While there are certainly staff whose conduct is impeccable and praiseworthy, the power that staff generally exercises and insignia of their status – uniforms, access to weapons and so forth – may evoke memories for children of harsh authorities who ill-treated them, their families and communities in their countries of origin.

An unaccompanied minor described detention as being like jail, stating that it provided him with a daily reminder of his time in detention in Iran and the beatings and torture that he experienced there. He stated that due to these reminders he continually felt unsafe. He felt alone and vulnerable as a small group of boys of his ethnicity in detention.

Inappropriate responses by staff to the behaviour of detainees can be re-traumatising for clients with a significant trauma history and contribute to their sense of fear for their own safety (for example, young people being placed in isolation following attempted suicide).

A 3.5 year old boy experienced significant trauma on the boat journey, having fallen off the boat and being submerged underwater before he was rescued. His post-traumatic symptoms included being terrified of water, frightened of everyone, clinging to his mother and biting her face, arms and body when upset. Serco staff took him to the water in an effort to help him with his fear of water, at which point he would scream. These staff were not trained in appropriate desensitisation techniques.

Children of a range of ages commonly report anxiety about being the target – actual or apprehended – of aggressive conduct including violence by people who are detained towards them and other detainees. The causes may be tensions between people of different ethnic backgrounds, the presence of individuals who have mental health problems which manifest violently, frustration and anger about delays in processing of asylum claims, or competition for access to communication equipment.

Children who have experienced sexual abuse feel particularly vulnerable living in close proximity to numerous adults, both other detainees and staff. Their fears are

heightened by reports – accurate or not – of detainees being sexually assaulted by other detainees in certain immigration detention facilities.³ Girls have also reported experiencing sexual harassment and unwanted male attention in an environment that forces them to live closely with men who are not their relatives.

Taking action to protect themselves from people they fear is more difficult for children in a detention environment than it might be in the community, particularly if the individuals who are perceived as threatening are staff members. Unaccompanied minors have reported advising detention facility authorities of incidents but that there was no effective action taken in response. To avoid contact with people who they fear, some of these young people restrict their movements within the facilities or even isolate themselves in their rooms.

Witnessing violence and self-harm by others in detention

Children who are our clients report having seen other people – including children – in detention threaten and engage in violent conduct (for example, fighting between detainees) and self-harm (for example, refusing to eat, cutting, lip sewing and hanging). Witnessing such events in closed environments is very distressing and manifests as behavioural and emotional problems including nightmares, heightened aggressiveness and hyperarousal (i.e. psychological and physiological tension producing symptoms such as insomnia, anxiety, attention disorder, risk-taking behaviours, exaggerated startle responses and memory or cognitive deficits).

An unaccompanied minor who intervened to stop a fight amongst a group of boys was hit with a chair and sustained an injury to his head. He was visibly distressed and frightened when he spoke about the violence that he had witnessed. Following this incident, he was unable to sleep during the night, his nightmares increased and his fear prevented him from getting his meals from the common dining room. He was very fearful of further violence at the centre.

Another unaccompanied minor said that he has increasingly isolated himself from others in an attempt to avoid hearing stories that remind him of the past. He said he is easily distressed by any aggression at the detention centre and reported vomiting following an incident where he saw another detainee bleeding after he had self-harmed.

Some young people relate to the acts of self-harm and violence that they are exposed to in detention and see such actions as the only way to express their distress in an environment that denies them normal coping strategies. Witnessing acts of self-harm can contribute to the development of self-harming behaviours and extreme psychological states of despair in young people.

³ See for example “Review into allegations of sexual and other serious assaults at the Manus Regional Processing Centre”, https://www.immi.gov.au/about/dept-info/_files/review-manus-offshore-processing-centre-publication-sep2013.pdf , viewed 10 June 2014.

An unaccompanied minor spoke of the sense of hopelessness he was feeling about his family and his situation. He stated that he was feeling tired of everything and that at times he felt like killing himself. He related to a young man like himself who had recently hung himself in detention.

Adverse effects on family functioning

A number of aspects of the detention environment impact adversely on the capacity of families to function well as units and in particular undermines parents' ability to undertake their responsibilities to nurture support and protect their children.

Families commonly live in tiny rooms in very close proximity to other detained families and individuals. The lack of privacy and of space specific to each family unit seriously constrains the ability of families to establish their own routines and practices.

A mother of a girl who was 4 years old at the time of detention explained that the lack of privacy led to her daughter overhearing other adults talking about the disappearance of the girl's father. This led to prolonged distress for the girl, who showed symptoms of complicated grief. The mother and daughter were sharing accommodation with two other families at the time.

Within held detention, parents do not have the autonomy to be the providers of basics such as meals. Parents frequently report that their children will not readily eat food prepared by the facility because it is unfamiliar to them and consequently suffer poor nutrition. Nor can they provide food if their children are hungry outside set meal times.

Parents report that their ability to maintain appropriate authority is undermined because they cannot effectively set limits on their children's movements and interactions. As well, they express feeling that they are "bad" parents because they find it difficult to protect their children from witnessing or being subjected to harm.

A family whose daughter was 12 years old had a conflict with another person in the detention centre and became worried about the daughter's safety as she slept on her own in a small room connected to the parents' room only by a bathroom. The daughter's room had a separate door to the hallway and the lock was not working, which meant anyone could enter her room at any time. To feel safer, the parents sometimes convinced the daughter to sleep with her mother, but on nights that she slept in her own room the parents would have difficulty sleeping and would constantly wake to check on their daughter.

FASSTT's work with many clients in detention and other sources including research studies demonstrate the deleterious effects on the mental health of adults in detention. Parents so affected may become less able emotionally and

psychologically to meet their children's needs. They may also experience acute anxiety and guilt that their actions have caused their children to be detained.

A family with a pregnant mother and two children, 6 years old and 12 years old, have spent over 8 months in detention (including 4 months in Nauru). Both parents have reported deteriorating mental health in detention including low energy and high irritability, which has resulted in increased family conflict. The parents feel that their parenting skills have been adversely impacted and they find it difficult to spend as much time as they would like with their children due to their low energy and low mood. They described finding it increasingly difficult to respond to their children's needs appropriately. They have also described becoming estranged from each other as a result of the effect that detention has had on the family dynamics.

Families have been separated across places of detention, for example, a child being placed in a different detention centre from their grandparent who was their primary carer; and mothers being separated from their families to give birth in another detention centre.

A mother in detention was flown to Darwin to give birth to her baby, being separated from her husband and 4 year old daughter who had to stay behind on Christmas Island. She found the birth traumatic as a result of her husband and child not being allowed to be with her. Her husband was only flown to Darwin 3-4 weeks after the baby was born, and the mother feels that the father missed out on the opportunity to bond with his newborn son.

An 18 year old girl and her family spent 8 months in detention centres before being transferred to community detention while the father, who was detained separately, remained in detention. The family had been separated from the father for 3 years. She spoke of how difficult life was without an adult male in the household to advocate, care for, and provide for rest of the family (which included an infant child). Her mother was suffering from severe depression and she had no option but to become responsible for caring for the needs of the younger siblings. She also suffered from symptoms of depression, including low mood, low energy, low appetite and weight loss, feelings of hopelessness for the future and social withdrawal.

Unaccompanied minor clients often report being separated from their family friends on arrival, often adult males who have been their carer during a traumatic journey. However, while they may have acted as a father figure, they may not be able to live together because they are not biologically related. Unaccompanied minors are also frequently separated from friends that they make in detention, who they think of as family, on short notice when they are transferred to different camps or into community detention. Friends can often function like a family group, looking after and

supporting one another and separation of group members can cause deep distress and anger.

An unaccompanied minor spoke of how difficult it was when he was moved from his first place of detention as he had gotten to know and trust others and it had become like a family environment to him. He says that he now sees his place of detention as temporary and will therefore not get close to others emotionally.

Another unaccompanied minor was offered community detention but refused because he was worried about leaving his friend in detention. His friend, who had suffered past trauma having witnessed the death of his brother, was not offered community detention and had reacted badly to the news that his friend might be released without him.

Some unaccompanied minors have close family members already living in Australia but are placed in detention facilities in different states denying them access to these critical support networks. This compounds their sense of isolation, loneliness and lack of support in detention. While some rely on their peers for support in detention, it cannot be expected that young people will necessarily befriend others in detention, and some experience isolation from their peers, a fear of going against the group and an inability within the confines of detention to remove themselves from situations of peer pressure.

Lack of meaningful and developmentally suitable activities

Clients frequently experience boredom, lack of stimulation and a sense of idleness in detention, “struggling to fill their days” and feeling like “every day passes like a year”. In some locations, unaccompanied minors report limited access to classes and meaningful activity and under school-aged children have not had access to developmentally appropriate activities such as pre-school and playgroups. Some facilities have reportedly lacked suitable space, opportunity and toys for children’s play.

An unaccompanied minor expressed being upset that English classes were only available from 11am-12pm daily. He was keen to keep occupied, which he said assisted to keep his worries out of his mind. He tried to fill in time as best he could between meal times. He was keen to learn English and was disappointed that he was not able to attend school during the three months he was on Christmas Island. He would like access to educational materials that could help him to improve his English language skills including a dictionary.

Another unaccompanied minor said that he is bored in the detention centre and would like access to reading and study materials. He said that education is important to him and that he is sorry that he has not been able to attend school, except for 20 days, in the 7 months that he has been detained.

A 1 year old child, who was the youngest of 8 siblings, was extremely isolated during the day as all of her brothers and sisters attended school or English classes in the day time and no playgroup or childcare was available for her. She therefore had no access to developmentally suitable activities and her mother, who suffered from depression, had no opportunity for respite. The child presented with a number of behavioural issues including frequent crying, tantrums and head-banging, sadness, boredom and separation anxiety. She also bit her mouth and nails, drawing blood, and this would increase during the day when she was most isolated.

Institutionalisation

Some young people released into the community after period as short as three months struggle with isolation and not having daily life an activities organised for them. The difficulties they experience adjusting to living in the community reflects their habituation to the regimented nature of the detention environment. A sense of learned helplessness occurs in detention and coping strategies become increasingly ineffective as the length of detention increases. There is no preparation for life outside of detention. This has also been the experience of some younger children who are our clients despite being with their families.

An unaccompanied minor conveyed his anxiety about being released when he said that he feels safer inside than outside because he knows all of the boys at the MITA.

Unaccompanied minors in detention are deprived of the normal reference points for the development of identity during the crucial adolescent period, which includes interactions with a peer group of their choosing, family and cultural community. Detention also restricts the availability of normal coping strategies and options for adaptive control, and as a result these young people often develop behaviours such as passivity, submission, withdrawal, excessive help-seeking, self-harm and in some instances violent protests.

A 17 year old boy with a history of trauma was suffering from severe depression and was socially withdrawn and isolated from his family. He began self-harming while in detention, and he regularly cut his body with sharps as a means of regulating his emotions.

Length and uncertainty of detention

Evidence from our work and others clearly demonstrates that the longer people are held in immigration detention, the greater the risk of deterioration in their mental health. This is the case for children as well as adults. The longer children are detained, the greater their exposure to an environment that is damaging to them and

to their parents. The negative impact of prolonged detention is exacerbated by uncertainty about how long it will last, unlike defined sentences imposed by courts.

A 17 unaccompanied minor with a significant history of trauma described the transformation that he had undergone from the time he arrived at Christmas Island, when he felt that he had saved himself and had hope of saving his family from danger, to his present situation in which he felt complete hopelessness, despair and extreme guilt at having failed them. He no longer had the capacity to be involved in activities that could distract him from the pain that he felt and he found it increasingly difficult to restrain from self-harm.

A counsellor who contributed to the preparation of this submission noted what she described as the “contagion of despair” among children in detention facilities as time passes. Children observe and are profoundly affected by each other’s sadness and loss of hope. They lose a friend who is released and don’t know when or whether they too will be released. They witness the deterioration of the health and coping capacities of their parents.

An unaccompanied minor stated that he was very upset by the negative mood at the MITA, with some boys having been there for 11 months. He said that there was deterioration in the mental state of those who had been there for long periods and described the marked deterioration in his own mental health from being happy when he first arrived to depressive. He said he finds the distressed mood of other boys at the MITA to be extremely upsetting.

Amelioration of impact of immigration detention

Evidence from our work with many children over many years indicates that it is certain that detention, particularly when prolonged, may be seriously detrimental to the health and wellbeing of children.

The evidence provides a powerful rationale for the requirement specified in the Convention on the Rights of the Child, that children should be detained only as a measure of last resort and for the shortest appropriate period of time (Article 37). The inquiry will enable the Australian Human Rights Commission to make a well informed assessment of the Australian Government’s compliance with this requirement.

In the course of working with many clients nationally over an extended period, our staff are privy to a significant amount of information about the application of the policy of detention and it is our strong impression that there are not explicit procedures in place and applied as a matter of course to ensure that people are detained only when reasonably necessary and for the shortest time possible and that the necessity for their detention is subject to periodic review.

If the policy of detaining children continues to be applied, then the Australian Government should ensure that measures are put in place to minimise the risk of harm. Based on our experience as described above, these include:

Family functioning

- If there is a family unit, members of the family should be kept together.
- To the extent reasonably practicable, family members should have the opportunity to function as a unit and retain significant family roles e.g. preparing their own food and eating together.
- Parents should have access to parenting support programs to assist them to support their children, particularly in addressing impacts of trauma on their children's development and repairing damage that trauma can do to the parent-child attachment.
- If parents are suffering from poor mental health, families should have access to support and resources developed for the Children of Parents with a Mental Illness team of the government-run child and adolescent mental health services.
- There should be readily accessible electronic means of communication with family and friends from whom they are separated.

Meaningful activities

- There should be comprehensive, age-appropriate educational and recreational services including activities outside the detention facility, suitable play spaces within the facility and playgroups and preschool for children under school age.
- School should be a priority for school aged children and the school routine should not be interfered with (for example, school days being cancelled for no apparent reason) as it provides an important and predictable routine for the child.
- There should be greater access to English classes and other educational activities, which provide both a meaningful activity and help to develop skills that are useful even if the person is returned or removed from Australia.
- Families and young people should have access to programs that help to prepare them for life outside of detention and counter the effects of

institutionalisation and also provide an opportunity to teach life skills to unaccompanied minors.⁴

Detention facilities

- Physical arrangements should afford a sense of physical security e.g. children should be separated from adults unless it is in their best interests not to do so, such as parents (as provided by Article 37(c) of the Convention on the Rights of the Child).
- Detention facilities should be located in places that have a general population (and not in remote areas) to enable access to appropriate services, visitors, community support, excursions and provisions.
- Detention centre staff and management should be trained in understanding the behaviour of detainees to ensure appropriate responses and conduct that is respectful and supportive of families and young people.
- To ensure food security, people should have access to food outside of mealtimes and access to food (and the ability to prepare food themselves) that is culturally and nutritionally suitable for young children, particularly babies and toddlers.
- Strong relationships between service providers operating within detention centres need to be encouraged as good interagency cooperation has been identified by our counsellors as achieving better outcomes for current clients and for clients in past detention settings.⁵
- There should be clear and transparent mechanisms in place that allow detainees to feel that they can safely make suggestions or requests within the detention-setting.

Other

- Children under 5 years of age should have access to early intervention services to help reduce the impact of trauma on their lifelong development (see Appendix 1).
- Information and assistance should be regularly provided about the determination of their protection claims.

⁴ For example, STARTTS run a version of their *Families in Cultural Transition Program* for asylum seekers and such a program could be tailored to the needs of specific groups such as unaccompanied minors. For information on FICT see <http://www.startts.org.au/services/community-services/fict/>.

⁵ Jasmina Bajraktarevic Hayward, "Documentation and evaluation of service provision at Singleton Haven Centre – From the point of view of service providers", <http://www.startts.org.au/media/Research-Doc-Documentation-at-Singleton-Haven-Centre.pdf>.

- Relationships with supportive caseworkers, family, friends from the community and volunteers should be facilitated and supported.

APPENDIX 1

Literature review by STARTTS on the impact of trauma on 0-5 year olds and the need for early intervention (which was not available while the children were in detention)

This literature review arose from the observed underutilisation of early childhood services among refugee families at STARTTS or other services (Signorelli 2011C). This raises concerns about **access by very young (0-5 year old) refugees, and their caregivers**, to programmes that can help to reduce the impact of refugee and resettlement trauma on the children, in the critical age where the brain is most plastic (Cozolino, 2006).

Zero to five year old refugees are vulnerable to lifelong development changes as a consequence of trauma (Center on the Developing Child at Harvard University – CDCHU – 2007; CDCHU 2010; National scientific Council on the Developing Child – NSCDC, 2005; NSCDC 2007a). **Early Brain development** is experience-dependent (Cozolino, 2006), and impacted positively or negatively by social, environmental and genetic factors (Schore, 2001). The negative changes, including trauma impacts, can be reversed or significantly reduced with appropriate early intervention (Ludy-Dobson and Perry 2010; NSCDC 2007a and b; Perry et al 1995).

Western studies show that trauma, pre-natal stress (Schore 2001), and early childhood stress can change brain structure (Centre on the Developing Child at Harvard University – CDCHU 2005, 2007; National Scientific Council on the Developing Child - NSCDC, 2007a, 2007b; Schore 2001; Interdisciplinary Council on developmental and Learning Disorders – ICDL – 2000; Perry, 2011) including the stress response mechanisms of the amygdala, vagal system, prefrontal cortex and both hemispheres (Cozolino, 2006). These changes particularly impact on socio-emotional information and bodily states (Schore, 2001). Early trauma and stress can also undermine the development of the cardiovascular system, immune system, and metabolic regulatory functions (CDCHU, 2010).

Very young refugees have been exposed to a wide range of interpersonal and environmental traumas and stresses, including direct trauma and the post traumatic and other mental health symptoms of their parents.

The impact of trauma will depend on the family situation, previous experiences, nature, recurrence, multiplicity, duration and type of traumas experienced by the child (Van der Kolk, 2005; Van der Kolk and Saporta, 1991; Van der Kolk, 2010). The younger the child is, the less able he or she is to make sense of what is happening, except through the parents' response (Van der Kolk, 2010).

Schaffer (2012) identifies additional settlement stresses relating to changes in roles and family and community support systems, and lack of knowledge and understanding of Australian norms, parenting practices, child protection systems and practices, laws, system and rights. These factors, in addition to previous experiences of state terrorism, can impede trust in western models of service provision.

Traumatised children may exhibit emotional and behavioural symptoms arising from the stress and trauma survival system activation. Like adults these may be

display as hyperarousal, hypoarousal, avoidance and intrusive phenomena. Hyperarousal may manifest as sensory and behavioural dysregulation, hyperactivity, aggression, impulsivity, attention disorder, risk taking behaviours (Van der Kolk and Saporta, 1991; Van der Kolk, 2005), anxiety and distrust (Van der Kolk, 2010; Tunnecliffe, 1996), memory or cognitive deficits (CDCHU, 2011; Coello, 2011), or language impairments (Van der Kolk and Saporta, 1991). The child may experience day dreaming, withdrawal and isolation lack of motivation, listlessness, apathy or helplessness (Tunnecliffe, 1996) the child may have frightening dreams, day dreams or re-enactment of traumatic experiences during play, repetitive violent play or drawings of traumatic experiences (Tunnecliffe, 1996). Children may present with a range of attachment disorders, separation anxiety, fear of abandonment, or generalised anxiety (Tunnecliffe, 1996). There may be self destructive preoccupations and behaviours (Van der Kolk, 2010; Van der Kolk and Saporta, 1991) or children may show signs of regression in their developmental skills (Tunnecliffe, 1996). Sometimes the child becomes over compliant because they are not able to protect themselves (Van der Kolk, 2005) and the parents may not perceive that this is a “surrender response” (Perry et al, 1995).

Physical symptoms of traumatised children can include pain, injuries, illness, changes to appetite, poor nutrition, low weight and reduced growth, psychosomatic reactions, auto immune disorders (CDCHU, 2007; Van der Kolk, 2010), gastrointestinal disturbances (Van der Kolk, 2005; Tunnecliffe, 1996) and respiratory disease (Van der Kolk and Saporta, 1991). There may also be delay in developmental milestones (Signorelli 2011B).

Early intervention is crucial (CDCHU 2007; Ludy-Dobson and Perry, 2010; NSCDC 2005; Perry, 1995; Schore 2001; Van der Kolk 1989; Van der Kolk 2005), because of the greater plasticity of the neural circuits that deal with stress in the foetal and early childhood period (NSCDC, 2005; Ludy-Dobson and Perry, 2010). Psychological problems can increase the pruning of neural pathways early in life (Schore, 2001) but intervention can prevent the disruption to attachment of the arising from death, separation or the parent’s unavailability because of post traumatic symptoms Schore, 2001.

Early interventions may help to prevent Post Traumatic Stress Disorder, re-traumatisation (Van der Kolk 1989, 2005, 2010; Schore, 2001), and maladaptive neuropsychiatric symptoms (Perry, 1995; Schore, 2010) later in life.

Prevention and recovery goals can be achieved in part by reducing the number and severity of early adverse experiences need to be reduced in number and severity, It is important to support and encourage the emotional availability of the caregiver (Schore, 2001; Cozolino, 2006),

Attachment, affect and relationship, which drive all development (Greenspan 2011), promote psychological well-being and affect and behavioural regulation (Schore 2001; Schore 2003a; Schore 2003b). The caregiver can provide a growth facilitating environment, and engage in reciprocal interactions (Cozolino, 2006; Schore, 2001). A wide range of healing and enriching strategies have been demonstrated to enhance the child’s recovery and development in areas such as sensory-motor development (CDCHU, 2007; Cozolino, 2006) motor development and motor planning (Perry, 2011), stable and responsive relationships (CDCHU, 2007; NSCDC,

2007; NSCDC, 2007b; CDCHU, 2010; Van der Kolk, 2005), and cognitive abilities (NSCDC, 2007). All these areas of development can be integrated, in the context of the caregiver – child relationships, through therapies such as play therapy (Cooper, 2009) and music therapy (Creighton, 2011; de l’Etoile, 2011;); Signorelli 2011a and b; Signorelli and Coello 2011; Signorelli 2011a and b; Signorelli, 2012 dance of lullabies). Behavioural and emotional regulation of parent and child are enhanced through the creation of the balance of the stress / survival mechanisms and the social nervous system (Porges and Gray, 2008; Cozolino, 2006; Signorelli and Dawlatly 2010, Signorelli 2011a) which will facilitate later learning and development (Perry, 2006).

Psychoeducation and modelling are provided for the caregiver in order to strengthen the caregiver-child relationship (CDCHU, 2010), encourage continuation of the activities with the child in the home environment (Signorelli, 2010) and help them to provide a growth facilitating environment (Schore, 2001), reciprocal interactions (Cozolino, 2006) and strategies for the parent and child to cope with trauma responses.

The STARTTS early childhood programme incorporates all these areas of work, drawing on the various evidence-based trauma recovery and developmental intervention models (Blaustein and Kinniburgh 2010; Herman (1997; Perry, 2006; Perry et al 1995; Greenspan, 2011; ICDL, 2000). All of these models, however, seem to have only been validated and evaluated with western societies and contexts, and no data is available on their validity for refugee families and communities, although Cozolino (2006) does reflect on the function of Buddhist meditation and differences between the communal mind and the individualism of “the West” (pp.327-332).

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