

PUBLIC HEALTH ASSOCIATION OF AUSTRALIA

**SUBMISSION TO THE NATIONAL INQUIRY into CHILDREN in
IMMIGRATION DETENTION**

BY THE HUMAN RIGHTS AND EQUAL OPPORTUNITY COMMISSION

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1. INTRODUCTION

The current mandatory detention policy of the Commonwealth of Australia breaches the fundamental principle of the rights of the child which is that children should be able to develop to their full potential. The policy breaches every article of the Convention on the Rights of the Child. The policy violates the right to health as established by international law.

The policy creates a significant risk of harm to refugee children who are incarcerated in detention centres, at all stages in their development to adulthood.

This submission will focus on the risk to the health of refugee children caused by the current refugee detention policy regime. The submission will refer principally to international human rights instruments in relation to their relevant health rights aspects. This emphasis is consistent with the health rights orientation and expertise of the Public Health Association of Australia.

Throughout the submission the term "refugee" is used to apply to all those who claim refugee status under the Convention. The definition of a refugee is that which is incorporated into the *Migration Act 1958* (Cth) by s 36(2) which provides for the granting of protection visas to applicants who are non-citizens to whom "*Australia has protection obligations under the Refugees Convention as amended by the Refugees Protocol*"

Such a person is defined under Article 1A(2) of the Convention as anyone who:

"owing to well-founded fear of being persecuted for reasons, of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality, and being outside the country of his habitual residence, is unable or owing to such fear, is unwilling to return to it."

In this submission the term refugee is applied presumptively for putative refugees until the status of applicants has been finally determined. It is submitted that those children rejected as Convention refugees should have their health rights and human rights respected and the obligations in regard to those rights still apply to the Australian Government whilst those children are subject to the jurisdiction of the Commonwealth of Australia.

2. SUBMISSION SUMMARY AND RECOMMENDATIONS

It is submitted by the Public Health Association of Australia that:

(i) Whilst there is a paucity [see section 7] of Australian research into refugee children's morbidity and psychological health in detention, international health research clearly establishes that:

(ii) Refugee children are *ipso facto* traumatised through the experience of oppressive danger and the fear of danger that has caused them to seek refuge as individuals, as members of the oppressed family or as members of the oppressed social, political, ethnic or gender groups.

(iii) The recovery of children from their refugee experience will vary according to the individual child's response to their experience and to the environment into which the child is placed.

Here the refugee experience is defined as comprising three distinct phases of oppression, flight and sanctuary.

(iv) As a signatory to the *Convention relating to the Status of Refugees* (1951) and its 1967 *Protocol* (the Refugee Convention) Australia is bound to offer sanctuary to refugees.

Sanctuary is relevantly defined in the Collins Australian English Dictionary as:

"2. a place of refuge or protection 3. refuge; immunity from punishment."

(v) Furthermore as a signatory to the *Universal Declaration of Human Rights* (1948), Australia is bound to treat refugees and those denied refugee status consistent with the human rights principles embodied in that binding human rights instrument.

(vi) The kind of sanctuary offered to refugee children should be determined by the human rights principle of the right to health, as established by Article 12(1) and (2) of the *International Convention on Economic, Social and Cultural Rights* (1966) and Article 24 of the *Convention of the Rights of the Child* (1989) (the health rights principles) and the bio-ethical principles of beneficence and non-maleficence.

(vii) In order to ensure refugee children's rights, policies which meet the needs of children must be formulated and implemented. The process of formulation of such health rights policies must be consistent with established public health principles of policy development. These principles require that through medical scientific methodology, population health risk indicators be established which are the basis of health policy formulation and implementation of consequent public health strategies.

(viii) A refugee under the Convention is presumptively defined. In this submission the definition of refugee is applied to all those who are claiming refugee status and either have not had their status confirmed or those who have had their status confirmed.

(ix) In addition it is submitted that those who have had their application for refugee status recognition rejected are still required to be treated by the Commonwealth of Australia in a manner that is consistent with human rights conventions and instruments.

(x) The scientific health research concerning child and adolescent trauma and post traumatic psychological conditions establishes a foreseeable risk that indefinite or prolonged detention of children will be harmful to their health in their immediate situation and their future.

(xi) The current regime of imprisonment and the inevitable consequent social isolation and deprivation fails to rehabilitate refugee children. This regime is positively counter to the

principles and obligations of international human rights conventions, public health and humane social policy.

(xii) The current refugee policy regime of the Australian Government fails to comply with the human rights health principles, good public health policy and causes risk of harm to refugee children.

(xiii) A refugee policy based on the health needs and in the best interests of children, consistent with the Commonwealth of Australia's human rights obligations should be developed and implemented as a matter of urgency.

It is recommended that an appropriate public health rights based policy for refugee children would be achieved by:

1. The immediate end to the detention of refugee children and their families. The process of determining refugee status should be consistent with health and child rights conventions and instruments to which Australia is a contracting state.

2. The establishment and implementation of an Early Childhood Care and Development Program for refugee children. The aim of the program would be the identification and diagnosis of early childhood care and development issues resulting from malnutrition and trauma experiences, with the implementation of appropriate Early Childhood Care and Development strategies combining appropriate infant stimulation, health care, nutrition, education and cultural support environments.

The management of the Program would be the responsibility of the Commonwealth Department of Health for funding, program development, monitoring and review. The program's implementation should proceed through the existing Refugee Health infrastructure.

3. The establishment and implementation of appropriate Care and Development for adolescent refugee children, stressing social reintegration and education assistance. Diagnosis, treatment and monitoring health care strategies for adolescents recovering from the refugee experience would be implemented as appropriately required.

The management of the program would be the responsibility of the Commonwealth Department of Health and implementation through the existing Refugee Health infrastructure.

3. ASYLUM SEEKERS - MANDATORY DETENTION POLICY OF THE PUBLIC HEALTH ASSOCIATION

The Public Health Association of Australia recognises that:

1. According to the *1951 Convention Relating to the Status of Refugees*, a refugee is a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country."
2. Under the United Nations (UN) 1951 Geneva Convention on Refugees, an agreement signed and ratified by Australia, we have a legal obligation to provide asylum to genuine refugees.
3. Australia's policy of mandatory detention for asylum seekers directly contravenes our commitment to the Universal Declaration of Human Rights (UDHR), which states that "[e]veryone has the right to seek and to enjoy in other countries asylum from persecution" (Article 14, UDHR).
4. Seeking asylum in a country other than one's own is not illegal, nor is it 'queue jumping', but rather a fundamental human right of any person experiencing persecution in their country of origin .
5. The overwhelming majority of asylum seekers are genuine refugees, fleeing persecution for reasons of race, religion, nationality, membership in a particular social group, or political opinion, which is perpetrated or condoned by the State or beyond State control. Experiences include torture, rape, imprisonment, threats of death, murder, and disappearance of family members .
6. Most asylum seekers are severely traumatised by the experiences they have lived through prior to their arrival in Australia, often chronic and repeated with cumulative psychological effects. Such experiences are documented torture and rape, witnessing the death of family members, separation from family and community, extreme material hardship and food scarcity, exploitation by border officials and camp guards, and appalling conditions during their passage to Australia .
7. Trauma experienced by asylum seekers is exacerbated by being placed in detention centres and the uncertainty about their future, resulting in reports of para-suicide, completed suicide and self-mutilation.
8. Australia's treatment of asylum seekers violates international human rights standards. The International Covenant on Civil and Political Rights (ICCPR) and the Convention on the Rights of the Child (CRC) prohibit arbitrary detention particularly of children .
9. The Refugee Council of Australia reported that as of 1 June 2001, there were 2,857 adults and 520 children, of whom 39 were unaccompanied minors, in Detention Centres. Detention Centres are inappropriate places for children, however, family units may not want to be separated. Detainees may be held in poor conditions and for long periods of time, often up to eighteen months.
10. The detention of children is a serious concern. It violates the Convention on the Rights of the Child, signed and ratified by Australia, and poses long-term risks to children's psychological and social development and well being, in particular their ability to successfully resettle in an Australian community .
11. The mandatory detention of asylum seekers is an excessive response that arbitrarily denies people of certain human rights; prolongs and exacerbates the trauma they have experienced

before and during their flight; denies them the possibility and security of normal family life; impairs their successful resettlement; and severely affects their mental health and well being.

12. The trauma and uncertainty of detention upon arrival is exacerbated by the denial of Permanent Residency visas to asylum seeking refugees who can obtain Temporary Protection visas for three years only, with limited access to resettlement services and inability to sponsor vulnerable family members. This places extreme pressure on those men who have left wives and children in situations of danger, in either situations of ongoing conflict in home countries or in unsafe refugee camps.

13. Australia has one of the lowest intakes of refugees of the developed world , yet it is the only one to mandate detention of all individuals entering the country without valid visas irrespective of whether or not they are seeking asylum .

The Public Health Association of Australia believes that:

Australia should fulfil its international legal obligations to protect the human rights of asylum seekers by fully implementing all Convention and Treaty obligations that Australia is signatory to.

The Public Health Association of Australia therefore recommends that:

1. The Federal Government should abolish the policy of mandatory detention for asylum seekers.
2. A Royal Commission should undertake an investigation into the conditions in current detention centres and the treatment of asylum seekers within these centres.
3. The Federal Government should establish an intersectoral collaborative working group that seeks to develop a model which conforms with its international human rights obligations.

The Public Health Association of Australia recommends, in the interim, that:

1. At a minimum, families with children, and without criminal records should be immediately removed from detention centres, to enable them to regain some family routine, to benefit from community support, to decrease their vulnerability to detention centre guards, and to provide the children with more freedom, access to education and better socialisation.
2. The determination of refugee status shall be expedited in order to minimise time in detention centres.
3. The Federal Government should require from Australasian Correctional Management (ACM), standard reporting in a transparent manner, to meet minimum quality of care guidelines, especially health care.
4. The Australasian Correctional Management (ACM) should immediately upgrade the resources and facilities available to asylum seekers in detention, particularly addressing the treatment of asylum seekers by ACM guards through training programs. Of particular concern is the use of tear gas and water canons to quell unrest amongst detainees.
5. The Federal Government should abolish the Temporary Protection Visa category, and provide permanent protection and asylum status to refugees

seeking asylum in Australia, allowing access to human services available the community.

4. THE PUBLIC HEALTH ASSOCIATION OF AUSTRALIA AND GUIDING PUBLIC HEALTH PRINCIPLES

Public Health Association is a non-government organisation committed to public health, the aims and objectives of which are constituted by the principles of the World Health Organisation Ottawa Charter. [1](#) Guided by these principles the Public Health Association of Australia policy is that effective public health is based on five essential strategies:

- consideration of public policy including the implications of education, transport, finance, housing, immigration and refugee policy for health policy.
- monitoring both social and physical aspects of the health environment including identifying qualitative and quantitative indicators of health in lifestyle, community organisation, the natural and built environments.
- educating communities in health advocacy and action including resourcing and teaching community members to evaluate state of the art information technology, utilising communications media and community development strategies in public health issues.
- developing individual skills in health advocacy including training the trainers, community consultation, conflict resolution and other skills needed in public health management.
- reorienting all community services towards the strategic perspective of preventative strategies involving the development of skills in strategic planning, organisational development and program evaluation. [2](#)

5. CONVENTIONS, TREATIES AND INSTRUMENTS

The relevant human rights and humanitarian treaties and instruments establishing health rights for refugee children are:

World Health Organisation Constitution (1948)

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." [3](#)

Universal Declaration of Human Rights (1948)

Article 25(1)

"Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." [4](#)

International Covenant on Economic, Social and Cultural Rights (1996)

Article 12

(1) The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

(2) The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:

(a) The provision for the reduction of the still-birth rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of the conditions which would assure to all medical service and medical attention in the event of sickness. [5](#)

The Declaration of Alma-Ata (Primary Health Care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978, WHO, 1978, p. 2)

Article I

The Conference strongly reaffirms that health, which is a stage of complete physical, mental and social well-being, and not merely the absence of disease and infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector.

and

Article V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organisations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

Recommendation 8.

The Conference, recognising the special needs of those who are least able, for geographical, political, social or financial reasons, to take the initiative in seeking health care, and expressing great concern for those who are most vulnerable or at greatest risk.

RECOMMENDS that as part of the total coverage of populations through primary health care, high priority be given to the special needs of women, children, working populations at high risk, and the under-privileged segments of society, and that the necessary activities be maintained, reaching out into all homes and working places to identify systematically those at highest risk, to provide continuing care to them, and to eliminate factors contributing to ill health.

Convention on the Rights of the Child (1990)

Article 24

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

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

- (a) To diminish infant and child mortality;*
- (b) To ensure the provision of necessary medical assistance and health care to all children with the emphasis on the development of primary health care;*
- (c) To combat disease and malnutrition, including within the framework of primary health care, through inter alia , the application of readily available technology and through the provision of adequate nutritious foods and clean drinking -water, taking into consideration the dangers and risks of environmental pollution;*
- (d) To ensure appropriate pre-natal and post-natal health care for mothers;*
- (e) To ensure that all segments of society, in particular parents and children , are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents;*
- (f) To develop preventative health care, guidance for parents and family planning education and services.*

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international cooperation with a view to achieving progressively the full realisation of the right recognised in this article. In this regard, particular account should be taken of the needs of developing countries.

Article 39

States Parties all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of; any form of human neglect, exploitation or abuse; torture or any other form of cruel, inhuman, or degrading treatment or punishment; or armed conflict s. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child."

6. PRINCIPLES - HEALTH AS A HUMAN RIGHT

"The problem of justice is closely related to the problem of a healthy order of society. It is concerned with the healthfulness of the parts as well as the sound condition of the whole. These two aspects of justice are, of course, inseparable. If the needs and aspirations of the individuals comprising society are reasonably taken care of by the system of justice, and if reciprocal concern for the health of the social body exists among the members of society, there is a good chance that a harmonious and flourishing society will be the result." [6](#)

The right to health has slowly evolved since 1946 through the key international human rights instruments identified in the preceding section. [7](#) The Vice Chairperson of the United Nation's CESCR has stated that *"although there was an abundant bibliography on health, very little of it related to health as a human right."* [8](#)

It has been argued that the right to health is rendered merely declaratory because a right must be enforceable and a guarantee for health is legally unenforceable. [9](#)

However, the right to health incorporates two enforceable rights, that of the right to health care and to a physical, economic and social environment which are the determinants of individual and public health. This interpretation of the right to health is consistent with the definition of health implicit in the international human rights instruments referred to above, Rights based public health is predicated on the thesis that;

- Health which is defined as a *"state of moral, mental and physical well-being"* is a human right.
- The main determinants of health are economic, political, social and cultural.
- The achievement of universal health is primarily dependent on the attainment of social justice and equity.

Applying this thesis, rights based public health analyses ill health and disease as being produced primarily by social structures of inequality and deprivation.

Rights based public health has developed within the context of the emergence of international human rights law. Public health particularly prior to the late nineteenth century was a utilitarian-based response to plague and disease. Epidemic control measures such as quarantine which derives from the Italian for 'forty days', which was the length of time deemed necessary to isolate the sick, were the first use of public health strategy to protect borders and populations. The strategy was based on the belief that illness resided in places which had to be kept separate, whilst those from the unsafe infectious places had to be kept out by a protective state. [10](#) This contagion model of public health relied upon the stigmatisation and exclusion of threat groups. An example is the stigmatisation of medieval lepers who were deprived of property and all other rights. [11](#) During the fourteenth century Jews were stigmatised as the carriers of plague, which led to pogroms and mass killings. [12](#)

Contrary to this exclusionary and discriminatory early form of public health strategy, rights based public health sees the achievement of universal health as a common good right dependent on social justice. Here health is defined broadly as *"a state of moral, mental and physical well being."* [13](#) In 1977 the Thirteenth World Health Assembly determined that the main health objective of the World Health Organisation (WHO) in future decades should be that of ensuring that the people of the world attain a level of health that would permit them to lead *"socially and economically productive lives."* This Health For All statement significantly recognises that the main determinants of health are economic and social and not to be narrowly confined to a health sector. [14](#) This perspective that sees the critical determinates of health and disease as economic, political, social and cultural and not spatially determined provides an inclusive and non-discriminatory basis for public health policy. [15](#) The struggle for social justice and the overcoming of exploitation are the strategic directions of rights-based public health. [16](#) Such a strategy is consistent with a common goods conception of rights. [17](#) The right to health is a fundamental group right. The importance of such rights is not merely that of the interest of the

right holder, but is justified on the basis of the common good which confers a stringency on the right beyond that of a justification of individual interests. The right to health rather than being relegated to that of a "second generation" right is a pre-eminent human right which justifies a precedence to the individual and common interests to which it relates when they clash with other interests. This provides a justificatory basis for the health rights of refugees to take precedence over the interests supporting a detention refugee policy. Public health, like unpolluted air is in the interest of everyone in society. The Commonwealth may argue that its detention refugee policy is in the public interest, but even if that were to be true, it would not be a common good since unlike rights based health it is not in everyone's interest.

Health is then one of a class of rights that are fundamental in that everyone, including refugee children have an interest which is non-competitive (their enjoyment of health is not at the expense of anyone else), is similar in nature for everyone (all enjoy it in the same way) and it serves the same interest in every person's case (though not everyone enjoys the benefit to the same degree). *"Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided. Equity is therefore concerned with creating equal opportunities for health and bringing health differentials down to the lowest level possible."* [18](#)

The last twenty years has seen the emergence of a rights based participatory public health movement characterised as the "new public health."[19](#) The two well-springs of rights based public health are the growing political and legal influence of international human rights instruments and the emergence of class and gender based social movements that have raised health issues such as with occupational health and safety, the women's movement, and the indigenous people's movement.

The right to a healthy life and environment is the ethical and legal basis which establishes the political and social imperative of public health. This ethic is grounded in the intrinsic value of life. Public health is also consequentialist [20](#) in the objective to achieve a healthy and just society for all people. The human right of health is applied and implemented through social change in a society of contradiction, exploitation and inequality.[21](#)

It is in the international health rights instruments that the legal basis of health rights is established. Human rights health law establishes multi-layered obligations and justiciable entitlements. Obligations on States are to respect, the duty to protect and the duty to fulfil. [22](#)

The duty to respect requires primarily that the Commonwealth as a duty holder refrain from direct violations of rights. This means that;

"wherever possible, to respect the freedom and the resources of those at risk, in order for them to find solutions to their own problem wherever they can." [23](#)

Whilst the duty to respect has been traditionally associated with individual negative based rights, the State may not positively infringe common goods rights such as creating the conditions for ill-health or negligently allowing disease or damage to the health of individuals or groups of people. The secondary obligation to protect requires duty holder States to prevent the right to health from being infringed by third parties. The role of the State in the protection of common goods rights such as health is *"similar to the protection of civil or political rights"* [24](#)

International human rights law provides precedents for a state obligation to protect individuals from infringing third parties.

"An illegal act which violates human rights and which is initially not directly imputable to a State (for example, because it is the act of a private person. . .) can lead to international responsibility of the State . . . because of the lack of due diligence to prevent the violation or to respond to it as required by the Convention." [25](#)

The Declaration on the Elimination of Violence Against Women places obligations on states in relation to
"violence against women, whether those acts are perpetrated by the State or by private persons." [26](#)

The European Court of Human Rights held that states have an obligation to protect individuals from the acts of third parties and that these obligations
" may involve the adoption of measures designed to secure the respect for private life even in the sphere of the relations of individuals between themselves." [27](#)

This decision is consistent with the approach of the UN Human Rights Committee which stated that:
"Positive measures of protection are. . . required not only against the acts of the State party itself, . . . but also against the acts of other persons within the State party." [28](#)

The obligation to fulfil requires duty holders to provide resources, such as
"to provide food, housing, health, and education (or a monetary entitlement sufficient to secure access thereto) to those in society without the means to provide for themselves." [29](#)

The multi-layered obligations on state duty holders to human rights, provide a rigorous standard for the Commonwealth in regard to the health rights of refugee children.

Convention Relating to the Status of Refugees

The Convention defines a refugee as someone with a *"well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion."* There are three elements to the refugee definition. A person must be:

1. In fear of being persecuted.
2. The fear must be a realistic response and cannot be imaginary.
2. The persecution must be on specified prohibited grounds.

Persecuted has been defined as implying a failure to protect against violence or ill-treatment by Lord Hope in *Horvath v Secretary of State for the Home Department* [2001] 1 AC 489 at 497-498

". . . the word 'persecution' implies a failure by the state to make protection available against the ill-treatment or violence which the person suffers at the hands of his persecutors."

Central to the definition of a refugee is the experience of fear and psychological trauma. The Macquarie Dictionary defines fear as "1. a painful feeling of impending danger, evil, trouble, etc; the feeling or condition of being afraid. 2 a specific instance of such a feeling. 3. anxiety or solicitude."

In regard to children, such experiences and feelings are clearly within the generic definition of child psychological maltreatment developed by the International Conference on Psychological Abuse;

"Psychological maltreatment of children and youth consists of acts of omission and commission which are judged on the basis of a combination of community standards and professional expertise to be psychologically damaging . Such acts are committed by individuals, singly or collectively, who by their characteristics (e.g age, status, knowledge, organisational form) are in a position of deferential power that renders a child vulnerable. Such acts damage immediately or ultimately the behavioural, cognitive, affective, or physical functioning of the child. Examples of psychological maltreatment include acts of rejecting, terrorising, isolating, exploiting, mis-socializing." (Proceedings Summary, 1983)[30](#)

Child refugees are by definition subjected to and suffering from psychological maltreatment and trauma. This is destructive to human development because it frustrates and/or distorts the fulfillment of basic psychological needs. [31](#)

There are three phases of the refugee experience:

1. Psychological trauma, which is very often associated with experiences of violence, rape and persecution
2. Flight
3. Sanctuary, which in Australia for many refugees is mandatory incarceration. The psychological trauma experienced by child refugees in these phases of the refugee experience requires the Commonwealth of Australia as duty-holder under the health rights international instruments and the Convention of the Rights of the Child and to implement policies which are consistent with those instruments and the Convention.

Convention of the Rights of the Child

The Convention as with health rights elevates the traditional categories of children's need to the category of rights, codifying them [32](#) and establishing the obligation of society to ensure that these rights are respected, protected and fulfilled.[33](#)

The Convention rests on four basic principles:

1. The best interests of the child
2. Non-discrimination
3. Participation
4. Survival and development.[34](#)

Specifically the right to health is established and incorporated by the Convention in all the following Articles:

- of all children to enjoy the rights of the Convention without discrimination of any kind (article 2)
- to survival and development (article 6)
- that the best interests of the child will be a primary consideration in all actions concerning children (article 3(1))
- for all children to participate meaning fully in all matters affecting them (article 12)
- to family life (articles 5, 9, 18)
- the highest attainable standard of health (article 24)
- practise their culture, language and religion (article 30)
- freedom from torture, ill-treatment and abuse (article 37)
- protection from all forms of physical or mental violence, sexual abuse and exploitation (articles 19 and 34)
- freedom of expression, thought and conscience (articles 19 and 34)
- protection as a refugee child (article 22)
- recovery from the effects of neglect, exploitation, abuse, torture or ill- treatment, or armed conflicts (article 39)
- not to be deprived of liberty unlawfully or arbitrarily, with detention only in conformity with the law, for the shortest appropriate period and as a last resort. (article 37)
- rest and play (article 31)
- privacy (article 16)
- a standard of living adequate for physical, mental, spiritual, moral and social development (article 27)
- if detained to be treated with humanity and respect for their inherent dignity and in a manner which takes into account their age.

7. THE REFUGEE EXPERIENCE AND THE CHILD - CHILD REFUGEE TRAUMA, RECOVERY AND SOCIAL REINTEGRATION

Refugee children suffer in many ways as a consequence of wars, internal conflict, repression and persecution. These experiences affect the health of children in many ways, using a broad definition of health which includes not only physical well being but also mental and social well being. The direct effects of war, repression and persecution on children include death, injury, disability, physical and sexual abuse, detention, loss of families through death and separation, displacement from homes and countries, and by definition psychological trauma. The indirect effects on children include poverty, poor living conditions, poor nutrition, poor health care, poor education, disruption of normal life, loss of family life and recreation and safety, discrimination and exploitation.[35](#)

Overwhelmingly the research documents the harmful effects of the refugee experience on children and the imperative of policies and health based programs of rehabilitation, recovery and social reintegration. These public health strategies and programs are consistent with the norms and principles of the Convention of the Rights of the Child, in particular *Article 39*.

"States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, abuse, torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child."

Article 39, Convention on the Rights of the Child.

Considerable international health research has documented the extent and effects of the psychosocial trauma and destruction that child refugees have been subjected [36](#) .

Traumatic experiences, such as the refugee experience can influence the child's emotional, cognitive and moral development, because the child's self image, expectations and understanding of the environment is influenced which can have profound developmental consequences.[37](#) Since the early 1990's, epidemiological studies in culturally diverse environments have documented high level of trauma in refugee groups.[38](#)

Psychic trauma is defined as " . . . the mental result of one sudden, external blow, or series of blows, rendering the young person temporarily helpless and breaking past ordinary coping and defensive operations. Trauma begins with events outside the child, through which a number of internal, lasting changes is initiated. Terr divides the effects of trauma into two main types: the effect of single events (type I trauma) and the effects of prolonged or repetitive extreme external exposures (type II trauma). While a number of reactions are the same disregarding the type of event experienced, the effects of long lasting or repetitive exposures follow a less predictable pattern than the effects of a single event, and can result in enduring personality changes.[39](#)

Research overwhelmingly indicates that experience of trauma is predictor of chronic psychosocial and mental health problems. [40](#)

Reactions after traumatic experiences have been known for some time under various designations - shell-shock, traumatic shock, traumatic neurosis, survivor syndrome [41](#)

However, it was only in 1980 that the diagnosis of adults for Post-Traumatic Stress Disorder (PTSD) was first included in the American diagnostic and statistical manual for mental disorders (DSM). Four criteria establish this diagnosis:

1. exposure to an extreme event outside the range of normal human experience,
2. repeated re-experience of the event or part of it,
3. persistent avoidance of stimuli associated with the traumatic experience and

numbing of the general responsiveness,
4. persistent symptoms of increased arousal.[42](#)

It was not until 1987 that the diagnosis of PTSD for children was formalised and recognised.[43](#)

There are two main reasons why it is more difficult to diagnose children with post-traumatic stress disorders and reactions. The early research had used general screening instruments which were unsuitable to assess child stress reactions. [44](#) Information was primarily gathered from parents and teachers,[45](#) who are known to underestimate children's reactions, partly due to their own overwhelming stress reactions [46](#) and partly because it is difficult, for parents also notice re-experience reactions and emotional numbing in children, [47](#) which are two of the four essential elements in a PTSD diagnosis.

The symptoms of post-traumatic stress disorder in children are often different from adults, dependent on the age and development of the child. In children the experience of fear, helplessness and terror can be expressed in disorganised or agitated behaviour. Specific for trauma in children are compulsory repeated behaviours or monotonous play, in which themes or aspects of the behaviour are expressed, nightmares without recognisable content, reduced interest in activities the child used to engage in with pleasure, trauma specific fear that is expressed at sensitive times before falling asleep, in the dark or in the bathroom, reduced confidence in self and others, a sense of severely limited future, and for small children, the loss of already mastered developmental competencies such as cleanliness or language. [48](#)

The psychological reactions of children subjected to severe trauma are not uniform, but are related to the context in which the experiences take place. From the existing research, it is appropriate to conclude that children who have been exposed to war, violence and persecution are all influenced by such experiences, but their reactions are dependent on their physical and psychological health, the presence or absence of parent/s, family and friends, their material conditions, their earlier experiences, the types of violent experiences to which they have been exposed, and the losses these experiences have caused.[49](#)

War, torture and other organised violence which characterises so much of the refugee experience have a profound effect on children. Prolonged and repeated exposures to trauma can have a profound influence on children's personality development through its impact on trust, values and morality. Torture and violence also have specific, well documented psychological effects that interfere with parenting making the children of torture survivors particularly vulnerable and at risk.[50](#)

It has been estimated that during the past decade some 10 million children were deeply affected and traumatised by armed conflicts and some 12 million left homeless and dispossessed by violence.[51](#)

The international community, through the international law in place for this purpose, has taken on a responsibility to "respect and ensure", inter alia, the recovery of children who are victims of armed conflicts consistent with Article 2 of the Convention of the Rights of the Child:
"State Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction. . ."

Immediately after the 1990 World Summit for Children, the then UNICEF Director stated that *"the leaders of the world have agreed to be guided by the principle of a "first call for children" - a principle that the essential needs of children shall be given high priority in the allocation of resources, in bad times as well as good times, at national and international as well as family levels."*[52](#)

The 1924 Declaration of Geneva contained five principles, one of which was that children should be the first to receive assistance in emergencies "[the] child should be the first to receive relief in times of distress." It is from the Declaration that the "children first" principle developed [53](#).

Violence has many negative effects on the psychological development of children and adolescents. Since World War II, the effects on children exposed to war and violence has attracted growing scientific attention. [54](#)

Early research tended to see child reactions to violence as mediated completely through parental experience and reactions and not to have long lasting effects on otherwise healthy children. [55](#)

Contemporary research has focused on more general aspects of the impacts on child development. Several studies indicated that child experiences of war and organised violence can have profound developmental consequences. [56](#)

The effect of war, violence and oppression on children has three distinct origins:

- (i) the child's own direct experiences, such as assault, beatings, and witnessing violence;
- (ii) the loss and separation from family and important family members;
- (iii) the impact of traumatic experiences on parental responsiveness and role function [57](#).

Epidemiological studies indicate that:

Children are not mere passive receptors of experience, but actively process and integrate experiences into an existing constructed social context. [58](#) Children react differently to trauma according to their age. [59](#) Pre-school children are most sensitive to traumatic events because of limited cognitive resources and the consequent difficulties of understanding and emotional processing of experiences. They are more dependent on the reactions of their parents because of feelings of helplessness when confronted with danger and need the most help from their surrounding emotional and physical environment. [60](#)

Post traumatic reactions include clinging to parents, violently protesting when left alone, afraid of going to sleep, anxious towards strangers and nightmares [61](#).

School age children have more cognitive, emotional and behavioural coping resources towards traumatic experiences. However psychosomatic problems, including poor concentration, a generalised attitude of arousal and fear of the future are linked to trauma experience. [62](#)

Adolescents because of their understanding of the consequences traumatic event are somewhat more vulnerable than younger children. They experience a premature and forced entry into adulthood. This can result in self destructive diversionary behaviour, pessimistic expectations and continued expectation of new trauma experience. [63](#)

The childhood experience of trauma and its sequelae are intertwined with parental and family functioning [64](#).

This is most obvious with parental loss and family destruction or disintegration as a consequence of the traumatic event. However, with children in families who experience trauma, post-traumatic disturbances in parental responsiveness and impaired parental role function are major causes of secondary stress. [65](#)

The acute emotional reactions of children following acute war related experiences can be summarised within the concept of Post Traumatic Stress Disorder. Social support, access to support from family or family substitutes, open and adequate communication with the family and the possibility of participation in play and structured activities can help children cope with such experiences. In addition post traumatic disturbances of parental responsiveness and role function renders children particularly vulnerable. Torture has specific, well documented psychological effects that interfere with parenting, therefore children of torture survivors are particularly at risk.

Detention and Pre and Post -Natal Health and Development

Research based evidence from the disciplines of physiology, education, and psychology overwhelmingly demonstrate that the early life years are the most critical.⁶⁶ The human brain's structure is biologically determined and develops in the prenatal stage of life. The connections in the brain that are significant to the foundation of later development are the consequence of the infant's interaction with social environments.

This critical period concept in brain development has been scientifically widely accepted for some time. The critical period occurs prenatally or very soon after birth. At this early development stage many changes are occurring in the brain at their most rapid rates. Effective endogenous or exogenous stimulation occurring during the critical period has long term consequences on subsequent development. Critical period of brain development involves a complex of change from rapid cell mass formation, various enzyme systems and electric brain activity rapidly approach adult characteristics and when external stimuli are most effective in causing long lasting behavioral changes persisting into adulthood.⁶⁷

An example of a single event catastrophic effect is illustrated in the case of malnutrition and brain development. During the first months of life the brain is the organ that grows most rapidly. In the first months of life the brain grows at about 2 mg per minute and by 14 months is approximately eighty per cent of adult size. In malnourished infants the shape of electroencephalographic peaks, as well as the frequency and amplitude of the waves occurs.⁶⁸

The most rapid brain development occurs in the first two life years, establishing the basis of future intellectual, psychological, physical and immunological development.⁶⁹ Environments that are stimulating of the child's senses coupled with good nutrition contribute to the healthy development of brain organisation and structure. Complex motor and perceptual experiences in infancy can enhance later life learning ability and even compensate for early nutritional and trauma disadvantage.

Based on this research, principles that facilitate early childhood health through appropriate care have been developed and are widely accepted and utilised in public health child strategies.

These principles of early childhood health facilitation and care are:

- Development commencement is prenatal and learning begins at birth.
- Factors determining the development of children are interdependent and multi-dimensional.
- The needs of children are various and complex.
- Development is multi-determined and dependent on nutrition and biomedical status, social and cultural contexts.
- Development is cumulative and not necessarily progressive.
- Development and learning is a participatory process for children.
- Development and learning are interactive and social processes for children.⁷⁰

Detention and the Principles of Early Childhood Care and Development

These public health child development principles clearly are incompatible with the detention of refugee children. In order to comply with health right instruments and sound public health principles of child development, child refugee programs should implement the principles and objectives of Early Childhood Care and Development. This holistic approach to child health recognises that physical, intellectual, emotional, spiritual development as well as socialisation, and the attainment of cultural values are interrelated factors in the health and life of the young child.⁷¹ Such an approach is consistent with refugee child policies that should be based on children's health and developmental needs and capacities. Therefore it is strongly recommended that the Commonwealth of Australia should have a child refugee health policy and program based on the principles of early childhood care and development which would be

appropriately resourced and applied to the needs of traumatised children with the objective of facilitating their recovery and social reintegration.

In order to implement such a public health program the current policy of detention of children and their families for prolonged periods would obviously need to be reviewed and comprehensively changed to a policy of refugee recovery and social reintegration.

The current prenatal and early childhood detention environment for refugee children is inimical to the healthy development of infants and very young children.⁷²

The establishment of alternative child and health rights based policies is imperative. Specifically, given the refugee experience of trauma the implementation of an Early Childhood Care and Development Program for refugee children is urgently required. A similarly targeted strategic public health program appropriate for older and adolescent children is similarly required. The aim of the programs would be the identification and diagnosis of childhood and adolescent care and development issues arising from malnutrition and trauma experiences. The strategies implemented would be to facilitate appropriate health, education and cultural support environments. These programs would be consistent with the Commonwealth of Australia's obligations under Ch IV of the Refugees Convention as amended by the Refugees Protocol, as a Contracting State to the Convention relating to the Status of Refugees and the Convention on the Rights of the Child.

The protection obligations imposed by the Convention upon the Commonwealth as a Contracting State relate to the civil rights of refugees.⁷³ In regard to refugee children clearly the current detention policy is a breach of those obligations and the children's rights. The socio-economic health standards enjoyed by most Australians and the feasibility of alternative public health rights based policy and programs for the benefit of refugee children makes this breach by the Australian Government particularly culpable and inexcusable.

8. CONCLUSION

Overwhelmingly international research indicates that refugee children suffer from the effects of the refugee experience with significant numbers experiencing Post Traumatic Stress Disorder. The dysfunctional environment of detention centres is a totally inappropriate social environment for such children. The health rights obligations of the Commonwealth and good public health policy requires the release from detention of refugees and their families as a matter of urgency to prevent the exacerbation of physical and psychological harms and to assist in the required rehabilitation and restoration of health to refugee children and their families.

The recovery of refugee children to whom Australia as a Contracting State to human rights Conventions has enforceable obligations can be reasonably achieved within the context of specifically designed and targeted public health programs. Only this kind of public health policy would comply with the Commonwealth's international health rights obligations. It should not be a requirement on the advocates of a health rights public health policy for refugee children to establish the need for such a policy. Rather, it should be incumbent on the Commonwealth to demonstrate how policies and the treatment of refugee children complies with its human rights obligations as a Contracting State. Clearly, the policy of detention of refugee children creates foreseeable harm and is contrary to accepted public health principles and is contrary to the large body of international research that documents the effects of the traumatic experience of refugee children.

The Public Health Association of Australia submits that the detention of refugee children causes harm to children, many of whom are ill and desperately in need of care. It is also submitted that the detention of refugee children breaches all principles of good public health policy. Refugee children should be assisted in recovery through sound public health policies without the moral, economic and social cost that is being imposed on the Australian community by the current policy regime.

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