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Developing services to meet the unmet needs of children under 12 from refugee-like backgrounds who are impacted by torture and trauma.

A qualitative exploration of the needs, challenges, and barriers to service delivery within the refugee services sector in WA.

ABOUT ASeTTS

The Association for Services to Torture and Trauma Survivors (ASeTTS) was established in 1992 to provide specialist mental health and rehabilitation services to asylum seekers and people from refugee-like backgrounds who have experienced torture or trauma in their country of origin, during their journey to Australia, or while in detention. Our services are designed for people who have arrived as refugees, asylum seekers, humanitarian entrants, people with permanent protection visas, and people from these backgrounds who have since become permanent residents or citizens in Australia. Support is provided to people of all ages through individual, family, group, intergenerational, or community services. Our highly skilled staff provide a range of direct services to survivors of torture and trauma their families and communities, which aim to diminish the impact of torture on survivors and enhance their opportunities to rebuild productive and meaningful lives.

ASeTTS is a member of the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT); a network of 8 specialist rehabilitation agencies that support survivors of torture and trauma across Australia. We are also a member of the International Rehabilitation Council for Torture Victims (IRCT); a civil society organisation that specialises in torture rehabilitation and has 160-member centres operating in 76 countries worldwide.

ACKNOWLEDGEMENT OF COUNTRY

ASeTTS acknowledges the traditional owners of the Wadjuk Boodjar (Perth land) where our offices are situated, and their continuing connection to land, sea, and community. We pay our respects to them and their cultures, and to elders past, present, and emerging. We are proud to be developing a Reconciliation Action Plan to promote harmony and understanding between the ASeTTS Board, staff, clients, and the Noongar people.

THANKS TO LOTTERYWEST

LotteryWest have generously granted ASeTTS funding to undertake this research which forms the first phase of a two-stage project. This research will inform ASeTTS on the development of contemporary, trauma-informed, age appropriate, and culturally safe models of service to support children under 12 and their families who are from refugee-like background and have experienced torture and trauma. We would not be able to complete this important work without the support of LotteryWest.

Version Control

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EXECUTIVE SUMMARY

ASeTTS provides a range of direct services to survivors of torture and trauma their families and communities, to enhance their opportunities to recover and rebuild productive and meaningful lives. Currently, ASeTTS delivers very limited services to children under 12-years; what is provided includes trauma counselling to a small number of children and short-term school holiday programs. The identified gap in supports have initiated the current research, which is the first of its kind undertaken in Western Australia (WA) and which has been generously supported by LotteryWest. This research forms the first phase of a two (2) phase project.

This research aims to map the true scope of services being provided to the target group in WA. Through the research that was conducted it became evident that there are limited services being provided to the target group in WA. Another goal was to quantify the population of interest. However, due to the lack of available information online (e.g., government reports) and from various organisations, this was not successfully achieved.

This paper reviews contemporary literature to identify therapeutic approaches that are recommended as effective in supporting traumatised children from a refugee-like backgrounds to recover and have positive relationships. Models that were reviewed include: trauma-focused cognitive behavioural therapy (TF-CBT), eye movement desensitization movement reprocessing (EMDR), narrative exposure therapy (NET), neurofeedback, play therapy and supported playgroup. The review highlighted that refugee children are severely under-represented within the literature.

The literature review is complemented by comprehensive qualitative research. Information generated through the qualitative research was coded and thematically analysed. Eight (8) key themes emerged from stakeholder consultations, these included: 1. The impact of trauma on families, 2. Mistrust and underutilisation of services, 3. Funding constraints and challenges, 4. Poor interagency collaboration, 5. Services lack trauma-Informed approach and cultural competency, 6. Few programs for refugee children, 7. Lack of service evaluation, and finally, 8. Few services in rural and regional areas.

Recommendations drawn from this research include opportunities that can be implemented within services in the short-term, for example in Phase 2 of this LotteryWest project. Short-term service development suggestions include: establishing supported playgroups, taking a holistic approach when supporting children from refugee-like backgrounds, delivering cultural competency and trauma-informed training to providers and educators, developing trauma-informed assessment tools for children, developing an in-school long-term group therapy program and a culturally safe parenting program, and establishing an interagency community of practice for providers supporting children from refugee-like backgrounds. Medium and long-term opportunities that could be developed outside the life of the ASeTTS' LotteryWest Project include (but are not limited to): implementing evidence-based trauma therapies within services, establishing ongoing youth group programs, and delivering parenting programs in partnerships with schools.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIP	Adaptive information processing
AMEP	Adult Migrant English Program
ASeTTS	Australian Services to Torture and Trauma Survivors Incorporated
CaLD	Culturally and linguistically diverse
CAMHS	Child and Adolescent Mental Health Service
CCPT	Child-centered play therapy
CEO	Chief Executive Officer
CICT	Children in Cultural Transition
COS-P	Circle of Security Parenting
CPRT	Child parent relationship therapy
DoHA	Department of Home Affairs
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
EALD	English as an Alternative Language/Dialect
EEG	Electroencephalography
EMDR	Eye Movement Desensitization Reprocessing
EMDR-IGTP	EMDR-integrative group treatment protocol
EVT	Empirically validated treatment
FASSTT	Forum of Australian Services for Survivors of Torture and Trauma
FDV	Family and domestic violence
fMRI	Functional magnetic resonance imaging
HSP	Humanitarian Settlement Program
IEC	Intensive English Centre
IRCT	International Rehabilitation Council for Torture Victims
LORETA	Low-resolution electromagnetic tomography
LTM	Long-term memory
NAPLAN	National Assessment Program – Literacy and Numeracy
NET	Narrative Exposure Therapy
NFT	Neurofeedback Training
NICE	National Institute for Health and Care Excellence
PTSD	Post-Traumatic Stress Disorder
PTSS	Post-Traumatic Stress Symptoms

SETS	Settlement Engagement and Transition Support
STARTTS	Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
STM	Short-term memory
TAU	Treatment as usual
TF-CBT	Trauma Focused-Cognitive Behavioural Therapy
Triple P	Positive Parenting Program
UNHCR	United Nations High Commissioner for Refugees
URMs	Unaccompanied refugee minors
WA	Western Australia
WM	Working memory

FIGURES AND TABLES USED IN THIS REPORT

ABSTRACT

Children of refugee survivors of torture and trauma are at a higher risk of suffering from mental and physical disorders than non-refugee children. Despite their evident need for assistance there are large gaps in trauma-informed care for refugee children in the literature and the refugee sector in WA. The present study used qualitative methods to understand the needs of refugee children, the challenges faced by members of the refugee community and service providers, the barriers to delivering services and the gaps within the sector. Purposive and snowball sampling were used to recruit stakeholders. Thirty (30) stakeholders engaged in semi-structured interviews. The interviews revealed eight (8) themes and eighteen (18) sub-themes. The themes included impact of trauma on families, mistrust and underutilisation of services, funding constraints and challenges, poor interagency collaboration, few programs for refugee children, lack of service evaluation and few services in rural and regional areas. The findings from the consultation and literature review were analysed to identify informed recommendations for the development of services to children from refugee-like backgrounds.

LITERATURE REVIEW

Introduction

In 2020, 82.4 million people were forcibly displaced worldwide as a result of *"persecution, conflict, violence, human rights violations or events seriously disturbing public order"*.[1] Of those that were forcibly displaced, only 34,400 were resettled; less than 0.05% of the displaced population and far fewer that the 107,800 people that were resettled in 2019. Half of those that were resettled in 2020 were under 18 years-of-age.

Children from a refugee-like background are at a higher risk of suffering from mental and physical disorders than children from non-refugee backgrounds.[2] Thus, there is a need to provide mental health support to children from this cohort. While there is a large amount of research surrounding the effectiveness of trauma-informed therapy on traumatised children from western backgrounds, there is very limited work that has investigated its effectiveness on children from a refugee-like background. While it is understood that people from refugee-like backgrounds have their own unique experiences and beliefs, and there are certain complexities in supporting refugee children most models of wellbeing and mental health support are western models. It is important to understand the benefits and merits of the accepted models of support, however, the application of these approaches when supporting refugee children should be done with caution.

This section of the report reviews the available literature to identify and evaluate appropriate trauma-informed therapy for traumatised children from a refugee-like background. This section also provides a brief overview of what trauma and intergenerational trauma is and the impact that trauma can have on the brain. It also endeavours to report the number of children between three (3) and twelve (12) who are from a refugee-like background and are experiencing trauma in WA.

Intergenerational Trauma

Children who have experienced being a refugee and/or have experienced torture and trauma, and children of refugee survivors are at a higher risk of suffering from mental and physical disorders than children from non-refugee backgrounds.[2] This is thought to be due to direct or intergenerational trauma.[3, 4] Intergenerational trauma is defined as the process by which *"trauma experienced in one generation impacts the health and well-being of descendants of future generations".*[4, 5]

Intergenerational trauma can occur through several different processes. Yehuda[6] found that parental post-traumatic stress disorder (PTSD) can impact the methylation of a glucocorticoid receptor gene in the offspring which can then impact their mental health of the child. Alternative research has shown that parents suffering from PTSD may experience behavioural changes which can impact their parenting style and subsequent attachment to their child.[7] Parents may become less sensitive,[8, 9] and more avoidant[10, 11]. In some instances they may suffer from anger and frustration difficulties which can lead to harsher parenting,[12] and increased hostility and overprotectiveness.[13] Research has found that children with parents who suffer from PTSD may begin to internalise or externalise their behaviours.[14] Children may also develop problems with conduct, hyperactivity, socialising and emotion.[15]

Polyvagal Theory

Stephen Porges[16-20] postulated the polyvagal theory which states that there are two branches of the parasympathetic nervous system: ventral vagal system and dorsal vagal system. The vagal nerve is the longest nerve in the autonomic nervous system, it starts at the medulla oblongata and travels to the gut. The dorsal vagal is evolutionarily older than the ventral vagal and is located at the back of the vagal nerve. It responds to cues of extreme danger by shutting down the nervous system leading to immobilisation and freezing. Conversely, the ventral vagal is younger and is involved in responding to feelings of safety and connection. A person in this state feels safe, calm, socially engaged and connected. Porges believes that an individual will always be in one of three states: ventral vagal, sympathetic, or dorsal vagal.

To preface the following explanation, one must understand the concept of neuroception which is the *"detection without awareness."* If an individual has the neuroception of safety, then their ventral vagal system will be activated. Thus, they will be socially engaged, calm, settled, grounded, mindful and connected. However, if an individual scans their environment and they have the neuroception of threat, danger, or unease, then their sympathetic nervous system will be activated. This is the mobilisation state where the individual chooses a fight or flight response. If an individual is unable to resolve the threat by using fight or flight, then they will travel to dorsal vagal state. An individual in this state has the neuroception of life threat and consequently will be immobilised, dissociated and numb. When an induvial has been exposed to trauma, there is a potential for their neuroception to become distorted.[21] When they are in ventral vagal and scan their environment, they may inaccurately view a stimulus as dangerous. Instead of moving from ventral vagal to sympathetic, they move straight to dorsal vagal. The following section will expand on how trauma can impact the structure and behaviour of the brain.

Impact of Trauma on the Brain

There are specific areas of the brain that are involved in PTSD symptoms. These include the amygdala, hippocampus, pre-frontal cortex, mid-anterior cingulate cortex, and right inferior frontal gyrus.[22] Trauma can lead to an over-activity of the amygdala resulting in hypervigilance and hyperarousal.[23] As a result, these individuals react to small triggers in the same manner as if they were experiencing or re-experiencing the initial trauma. This hypervigilance can lead to difficulties sleeping and relaxing.[24]

Another area of the brain that is impacted by trauma is the hippocampus, which is involved in processing explicit memories, encoding context, and consolidating memories from short-term into long-term storage. Damage to the hippocampus can change the way an individual remembers and recalls memories.[25, 26] Research shows that traumatised children have a smaller hippocampus volume than those who have not been exposed trauma.[25, 27, 28]

Children exposed to abuse show altered social and emotional processing.[24] This area of the brain involved in this processing, the ventro medial pre-frontal cortex, has reduced thickness suggesting immature development.[25, 29, 30] These individuals have also shown to be hyper-sensitive to emotional stimuli.[31] Children with trauma also present with inferior attention-processing and executive function and have difficulty with planning and problem-solving.[32] Interestingly, trauma can lead to changes to the right inferior frontal gyrus which can lead to impulsive behaviour and engagement in high-risk activities.[33]

Brain imaging studies have also shown decreased levels of gray and white matter in the pre-frontal cortex of youth exposed to childhood trauma compared with those who were not exposed.[34] Moreover, the survival mechanisms, within the brain of traumatised children become more dominant than their learning

mechanisms which can result in a range of impairments and developmental delays.[35] The following table highlights the common trauma symptoms for children under the age of twelve (12).

Table 1. Symptoms in children affected by trauma

Age		
0-2 years	**2-4 years**	**5-12 years**
• Alarmed by cues • Behaviour changes • Changes in appetite • Clinginess to anyone (including strangers) • Decrease in responsiveness • Decrease in vocalization • Excessive clinginess • Heightened arousal • Inconsolable crying • Regression in acquired developmental skills	• Aggression, and anger towards themselves • Attention-seeking, defiance aggressive behaviours • Avoidance of reminders • Decrease in responsiveness • Development of new fears unrelated to trauma • Difficulty concentration • Increased physical complaints • Loss of confidence • Regression in acquired developmental skills • Relationship difficulties with caregiver, siblings, peers • Reliving of trauma • Sad and withdrawn • Sleep problems	• Anxiety and fear for their loved ones' safety • Appetite changes • Avoidance • Behaviour changes • Changes in arousal and reactivity • Changes in mood and thinking • Decline in school performance • Emotional distress • Increase in physical complaints • Intrusion • Withdrawal from family and friends

Adapted from Rebuilding Shattering Lives[36]

Number of children in population of interest

One aim of this research was to develop an understanding of the true number of children between the ages of 3 and 12-years who are from refugee-like backgrounds and who have lived experience of torture and trauma (direct or indirect). Children who would benefit from the development of specialised services. Data collated from the Department of Home Affairs (DoHA) and the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) shows that there were 401 new arrivals under 12-years from the humanitarian stream in WA between 2019-2021. This is 30% of the total new arrivals in WA from the humanitarian stream during this period.

This data severely underrepresents the true population of interest. It is important to note that the humanitarian stream does not include individuals on 100 visas nor those that are asylum seekers. It also does not factor in Australian-born children who have parents from a refugee background. Although these individuals may not fit the Humanitarian Settlement Program (HSP) criteria, they may still require specialist services, and as such capturing their numbers is important. Furthermore, this data focuses on individuals

who arrived in WA between a two-year period rather than combining these figures with those who have already settled in in the state.

It is interesting to note that ASeTTS saw seventy-four (74) children under the age of 12 between 2019-2021. This is approximately 18.45% of the newly arrived children from this age group. Considering that the data of the population of interest is underreported, this means that the percentage of those that are receiving trauma counselling by ASeTTS is even smaller.

The initial goal to draw data from various sources to accurately capture the cohort of interest was unsuccessful due to the lack of available information both online (e.g., government reports) and from various organisations that contributed to this research. While contributing organisations were encouraged to capture and share their client demographics, ASeTTS could not ensure client records were not duplicated as many people from refugee backgrounds access supports from multiple service providers. Data is not being captured as effectively as it could, or in a consistent manner; and data available from government is sometimes inconsistent or limited in scope.

Ongoing and coordinated efforts are required across the services sector to identify the true number of children who fit this cohort and may benefit from specialised services. Without an accurate understanding of the numbers, need and demand for trauma-informed services, it is difficult for providers to develop and plan effective long-term programs of service for children from a refugee-like background.

Trauma-Informed Services for Refugee Children in WA

The primary service available for children between three (3) to twelve (12) and their family in WA is supported playgroups. These playgroups are delivered in either ethnic specific groups or mixed-ethnicity groups. The playgroups are primarily delivered on school grounds and in collaboration with refugee- or migrant-related services. While one-on-one therapy is available for refugee children, it is primarily delivered by ASeTTS and a very small number of Child and Adolescent Mental Health Services (CAMHS) clinicians.

There are a limited number of school-based programs and school holiday programs delivered to refugee children. Child in Cultural Transition (CICT) is delivered under the Settlement Engagement and Transition Support (SETS) program, which limits the program to humanitarian entrants who have been living in Australia for less than 5-years. This does not consider children that are Australian citizens with parents who are refugees and require assistance with acculturation and becoming familiar with norms, laws, and community expectations in Australia. There is also a limited number of parent education programs delivered. The following figure maps the services and programs that are currently being delivered to refugee children and their families.

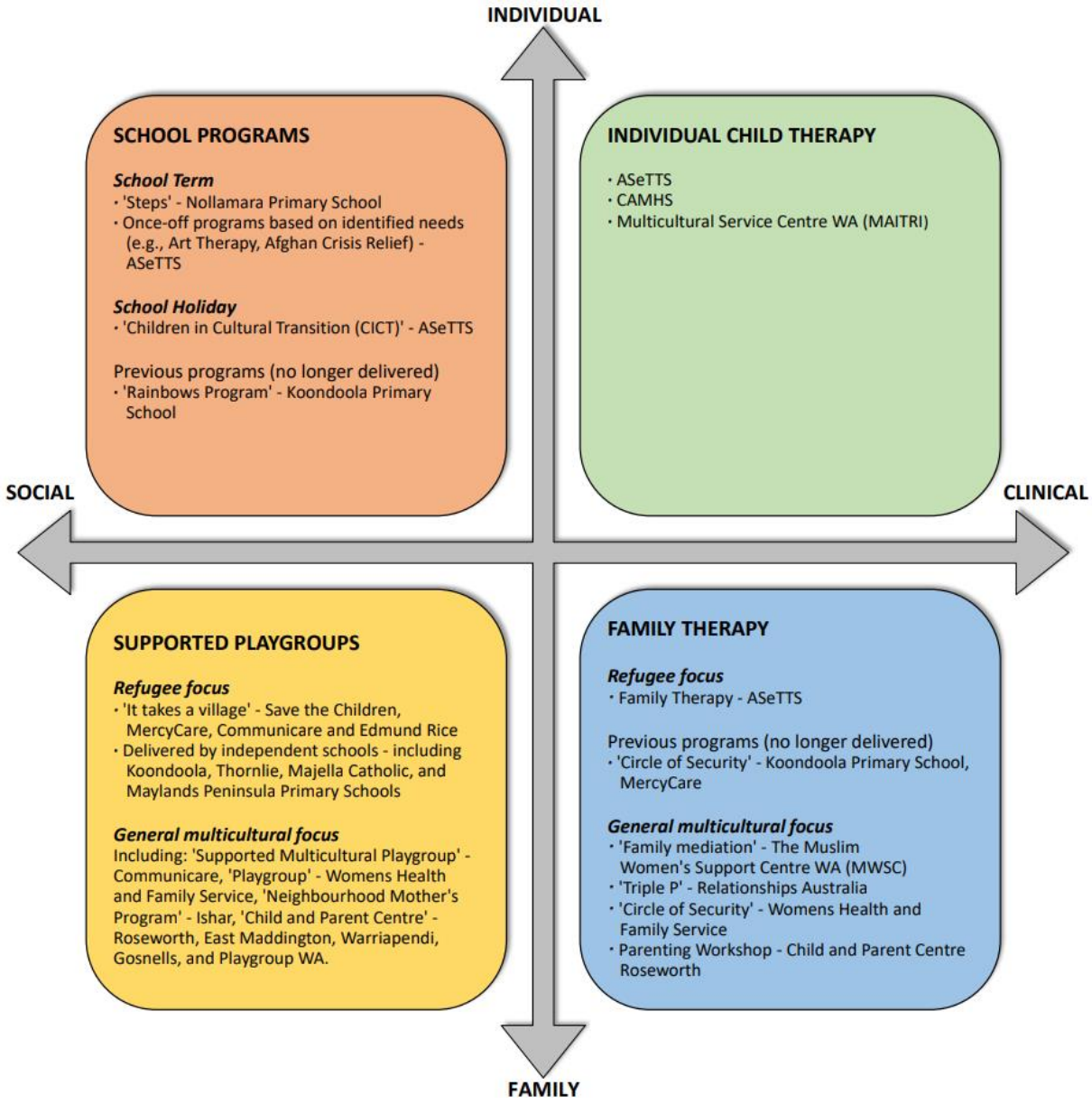

Figure 1. Trauma-Informed Services Available for Refugee Children (3 to 12-years) in WA

Trauma-Informed Therapy for Children

The 2018 National Institute for Health and Care Excellence (NICE) guidelines recommend that children who have experienced a traumatic event within one month of seeking treatment should engage in Trauma-Focused Cognitive Behavioural Therapy (TF-CBT).[37] In instances where the child is between the ages of seven and seventeen and has been exposed to a large-scale trauma, NICE guidelines suggest that they engage in group TF-CBT that last between five (5) to fifteen (15) sessions.

For children between the ages of five (5) and six (6) who have been exposed to trauma over one month prior to engaging in counselling and are presenting with a diagnosis of PTSD or clinically important symptoms of PTSD, the guidelines recommend that they engage in individual TF-CBT. This recommendation is the same for individuals between the age of seven (7) and seventeen (17) who engage in treatment after one month and present with PTSD or clinically important symptoms of PTSD. It is advised that Eye

Movement Desensitization Reprocessing (EMDR) is delivered to children between the ages of seven and seventeen who have not responded to TF-CBT.

The NICE guideline's view 'traumatised children' as a homogenous group and fail to distinguish the difference between traumatised children from a western background, and those who are from a refugee-like background. Despite the effectiveness of TF-CBT and EMDR on children from western backgrounds, it would be difficult to generalise these findings to refugee children without conducting research with this population group. Thus, this section will identify and examine studies that have investigated the effectiveness of these approaches on refugee children as well as finding other therapies that are being conducted on refugee children. Additional approaches that have been beneficial to traumatized children include narrative exposure therapy (NET),[38] neurofeedback,[39] and play therapy.[40, 41].

1. Psychotherapy

a. Trauma-Focused Cognitive Behavioural Therapy

Background

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is a short-term, evidence-based, therapeutic intervention that is delivered to children, between the ages of three (3) and eighteen (18), and their families.[42] TF-CBT is comprised of eight (8) components; psychoeducation and parenting training, relaxation, affect expression and modulation, cognitive coping, trauma narrative and processing, in vivo mastery (gradual exposure), conjoint sessions (parent involvement) and enhancing safety and future development.[43] Although TF-CBT is the recommended first-line treatment for children and adolescent with PTSD and multicomplex traumas,[37] the research examining its effectiveness among refugee children is scarce.

Evidence of Effectiveness

A randomized control study compared the effectiveness of child-centered play therapy (CCPT) to Trauma Focused Cognitive Behavioural Therapy (TF-CBT) in reducing post-traumatic stress symptoms (PTSS) in traumatised refugee children.[44] Thirty-one children, aged 6 to 13, were randomly allocated to either a TF-CBT or CCPT group. The interventions were delivered for approximately 12 weeks. For the whole sample there was a non-significant reduction in severity ratings for posttraumatic stress symptoms, on both the child and parent reports, from pre- to post-test for both groups. However, for the sample of participants who met the criteria for full PTSD, there was a statistically significant decrease in severity ratings for PTSD, on both reports from pre- to post- test for both interventions, with no differences found between the two groups. These findings suggest that TF-CBT and CCPT are successful in ameliorating symptoms of PTSD in refugee symptoms. However, the study's small sample size and high proportion of African participants limits the generalisability of the findings to the wider refugee population.

Unterhitzenberger et al (2015)[45] found similar results when they examined six (6) case studies from a wider randomised control study, to investigate the effectiveness of TF-CBT in reducing PTSS among unaccompanied refugee minors (URMs). The sample consisted of six (6) severely traumatised URMs who were between the ages of sixteen (16) and eighteen (18). While this, and the following studies, are outside of the age range of interest for this literature review, it does show that TF-CBT resulted in positive outcomes for those from a refugee-like background. The authors reported a statistically significant reduction in PTSS from pre- to post-assessment. All of the participant improved by more than 50% and all but one participant was considered 'recovered' from PTSD at post-test. While this study showed that TF-CBT reduces symptoms

of post-traumatic stress among URMs, the study does face several limitations. Firstly, the study has a small sample size and thus the findings cannot be generalised to the wider population of URMs. Secondly, the authors were unable to determine whether the reduction in symptoms were due to the intervention itself or the increase in attention provided during the treatment. Thirdly, all of the participants excluding one had modifications made to their treatment. Finally, there was no control group or follow-up data conducted.

The following year Unterhitzenberger and Rosner (2016)[46] built on the previous study by examining the long-term impacts of TF-CBT on a seventeen (17) year old female refugee living in Germany. The participant and her caregiver attended twelve (12) individual TF-CBT sessions. The participants symptoms significantly reduced at the end of the treatment and remained stable at the 6-month follow-up. Remarkably, at post-test and follow-up the participant no longer fulfilled the criteria for PTSD diagnosis. Interestingly, the caregiver reported a significant reduction at post-test, however at follow-up assessment they reported a non-significant increase. The study shows promising findings to supports the utilisation of manualised TF-CBT among URMs. However, as this is a single case study the generalisability to the wider refugee community is limited.

More recently Unterhitzenberger et al (2019)[47] conducted an uncontrolled pilot study to investigate the impact of manualised TF-CBT on URMs with PTSD. There were twenty-six (26) participants between fifteen (15) and nineteen (19) years. The participants received on average fifteen (15) TF-CBT sessions and were assessed at four-time points: pre-intervention, post-intervention, 6-weeks follow-up and 6-month follow-up. Participants' PTSD symptoms significantly decreased from pre-test to post-test with a large effect size. The samples' PTSD symptoms remained relatively stable at both 6-week and 6-month follow-up assessment. Approximately 84% of PTSD cases recovered after participating in TF-CBT treatment. Not surprisingly, after 6-months those participants whose asylum seeker request had been rejected reported an increase in PTSD symptoms. Despite these initial findings providing evidence for TF-CBT, the study lacked a control group and had a small sample size.

Limitations of TF-CBT

While research shows that TF-CBT is effective in reducing PTSS, a meta-analysis showed that one third of participants failed to respond to TF-CBT.[48] In addition, the recovery rate of PTSD is only 56%. TF-CBT also has the potential to temporarily worsen symptoms for participants.[49] Thus, it is not ideal to use this therapeutic approach with individuals with suicidal ideations or substance abuse problems. Furthermore, TF-CBT is considered inappropriate for participants presenting with conduct problems or behavioural problems which were present prior to the traumatic event.[49] It is recommended that these problems be dealt with prior to addressing the trauma. Another potential limitation is that if children are developmentally delayed, they may not be able to *"play with their mind"* and thus play therapy might be a more appropriate technique. Furthermore, the research surrounding the impact of TF-CBT on traumatised refugee children is very limited.

b. EMDR

Background

Eye Movement Desensitisation Reprocessing (EMDR) is an empirically validated treatment (EVT),[50] used to assist individuals who have been exposed to single or multiple traumas. [51] EMDR is based on the adaptive information processing (AIP) model and is used to help clients to reprocess their traumatic memories. This psychotherapy approach can be delivered in both a one-on-one and group format.

In EMDR treatment there are eight phases; history taking, preparation, assessment, desensitisation, installation, body scan, closure and reassessment. [52] In EMDR the client activates their traumatic memory, or in the case of multiple traumas, the earliest event. Attending to the trauma memory moves it from the long-term memory (LTM) to the short-term memory (STM) or working memory (WM). While focusing on the event the client will elicit the image of the event and express their current emotion, bodily sensations, and negative beliefs they hold about the event and their desired positive belief.

The desensitisation phase focuses on moving towards adaptive reprocessing. The clinician will rapidly move their fingers back and forth horizontally asking the patient to follow the finger movement with their eyes. This bilateral stimulation activates both sides of the brain and over works the WM. The bilateral stimulation and recall reduce the vividness and emotional charge of the memory. This allows the client to discuss the trauma memory without any negative or overwhelming feelings. Consequently, the client will be more equipped to reprocess the memory. This process terminates when the client states that they are no longer distressed by the traumatic memory.

Evidence of Effectiveness

Individual EMDR

Although a relatively old study, Oras et al (2004)[53] examined the impact of EMDR on 13 refugees between the ages of 8 and 16. For the children above the age of 13 individual EMDR was supplemented with conversational therapy and for those below the age of 13 it was accompanied by play therapy. At post-assessment there was a significant decrease in the mean scores from pre-intervention to post-intervention, for total PTSS, PTSD-related and non-related symptoms as well as symptoms of re-experiencing, avoidance and hyperarousal, and a significant improvement in functioning level, and depressive symptom. Interestingly, all but one participant made significant improvements. One client reported an increase in avoidance and hyperarousal scores at post-treatment. This was thought to be due to the participant suffering from psychological problems prior to being exposed to the trauma event. Interestingly, despite the significant improvement in depression scores, there were five participants who did not improve on the item 'depressed mood'. The authors believed that this may be due to depressed moods becoming salient or unchanging as PTSD symptoms decrease. This study provides findings to support the use of EMDR to reduce PTSD, however not depression. Moreover, the study had a small sample size, no control sample, and the findings may be confounded by the additional intervention; play or conversational therapy.

Wadaa et al (2010)[54] built upon these findings by conducting a non-randomised control trial to assess the impact of EMDR on 37 Iraqi refugees between the ages of 7 and 12. The children self-selected to participate, and those who refused formed the control group. The participants attended 12 sessions of EMDR over the course of 3 months. The mean scores for PTSD symptoms for the intervention group significantly decreased from pre-treatment to post-treatment. However, for the control group there was a small non-significant reduction in the control group. Despite these positive findings, the study did not assess the long-term impacts of the intervention on PTSD-related symptoms.

Group EMDR

Due to its cost-effectiveness, more recent research has examined the impact of group facilitated EMDR sessions on reducing PTSD among refugee children. Hurn and Barron (2018)[55] delivered four 3-hour EMDR-integrative group treatment protocol (EMDR-IGTP) to eight children between the ages of 6 and 11. The children's ratings of disturbance substantially reduced after attending EMDR-IGTP. In addition, the children's pictures used to indicate level of disturbance shifted from negative to more positive emotions at

post-intervenient. While the participants' level of disturbance reduced, the study utilised qualitative measures which are subject to its own limitations and fails to measure the size of change. This along with the small sample size, limits the generalisability of the findings to the refugee population.

To overcome this Molero et al (2019)[56] conducted an RCT study to assess the impact of a group-based EMDR model on refugee children. The sample consisted of 66 males between the age of 13 to 17 years old from six (6) refugee sites. The sample was randomly assigned to an EMDR group or control group. The statistical analysis was conducted on 30 individuals from the treatment group and 33 from the control. The mean PTSD scores significantly reduced from pre- to post-assessment, and from pre- to follow-up assessment in the EMDR group. However, there were no changes over time in the control group. Interestingly, there was a significant difference in PTSD scores at post-test and follow-up between the intervention and control group. In the treatment group there was a significant reduction in anxiety and depression scores from pre- to post-test. However, there was no significant difference found for these variables in the control group. There was a significant difference between the intervention and control group at post-test for both anxiety and depression scores. These results provide support for group based EMDR, however, there was no formal diagnosis of PTSD and the sample consisted of only males.

The following year Lempertz et al (2020)[57] investigated the impact of EMDR-IGTP on 10 refugee children aged, between the ages of 4 and 6, from Syria and Afghanistan. Participants engaged in 5 daily sessions of EMDR-IGTP. The mean total PTSD scores reported by teachers significantly reduced from pre- to post-intervention and, from post- to 3-month follow-up, both with high effect sizes. However, the parents failed to report a significant reduction in total PTSD scores over the three assessment points. The ratings provided by the pre-school teachers and parents did not significantly differ over time for total PTSD scores. Although these findings are positive, the sample was small and there was a high attrition rate which resulted in several missing scores at follow-up. Furthermore, the translators and parents had issues understanding the responses which reduced the accuracy of the reports.

A very recent randomised controlled study conducted by Banoglu and Korkmazlar (2021)[58] examined the effectiveness of EMDR in reducing PTSD symptoms among 61 Syrian refugees between the ages of 6 and 15. At post-treatment there was a statistically significant improvement in PTSD symptoms, depression symptoms, and wellbeing scores in the EMDR treatment group compared to the control group. The authors also found that the themes of the participants drawings shifted from negative themes (tanks, bombs, dead people) at pre-treatment to more positive ones (animals and sunny weather) at pot-treatment. This study builds on the evidence supporting the use of EMDR to assist traumatised refugees. However, the authors failed to report the stability of improvements over time.

Limitations of EMDR

While EMDR is recommended practice for children exposed to trauma, the evidence supporting EMDR is weaker than TF-CBT. The primary concern surrounding EMDR is that it can heighten participants level of distress.[59] EMDR can lead to unexpected reactions such as high level of emotional or physical sensations. Furthermore, EMDR can also lead to participants to ruminate on trauma events through memories or dreams. While this is a concern this is considered essential for repressed feelings, emotions, and memories to be revealed in order to achieve successful recovery. Furthermore, the psychologist will ensure that clients is not in a distressed state when they leave, he session.

c. Narrative Exposure Therapy

Background

Narrative Exposure Therapy (NET) is a short-term, evidence-based therapeutic technique that integrates testimonial and exposure-based therapies to treat adults who have been exposed to multiple traumatic events.[60] An adapted version, KIDNET, has been created for children who are dealing with PTSD. When an individual experiences an emotional event the brain encodes both the sensory ('hot memories') and contextual information ('cold memories') associated with the event.[61] The sensory, cognitive-emotion and physiological features of the event is processed into the long-term perceptual memory while the contextual and verbalisable aspects of the event are processed into the episodic memory. As an individual experiences more traumatic events, these experiences may become incorporated into the fear network or integrated into prior traumas. If this occurs, then the connection between the cold and hot memories may weaken. Consequently, with each new traumatic experience the fear network increases and the connections between the hot and cold memories deteriorate. KIDNET works by activating the hot memories and reconnecting them with the contextual information from the cold memory.

Structure

In KIDNET the therapist works with the child to construct a visual timeline of their life from birth to present. The timeline is often represented with a string or rope. The timeline includes the important events that have occurred in the child's life including positive and traumatic events. The child then represents each event using objects such as stones and flowers to symbolize the bad and good events, respectively. In each session the therapist works with the child to process a single traumatic event. The child will access the hot and cold memories linked to the event. The therapist guides the child through the traumatic event as they describe in detail the contextual, sensory, cognitive, emotional, psychological, and behavioural information associated with the event. The therapist assists the child to regulate their emotion as they discuss the traumatic event. The therapist writes the child's account of the event and then reads the narration to the child to ensure that it has been recorded accurately. This is repeated until the biography is completed. In the final session, the therapist reads the complete biography to the child. The child's repeated exposure to the detailed narration of the traumatic event helps to desensitize them and decrease their hyperarousal and avoidant behaviours. NET enables the child to accurately integrate the contextual and verbalized aspects with the sensory memories into coherent and meaningful stories.[61]

Evidence of Effectiveness

Ruf et al (2010)[38] conducted a randomized control study with 26 refugees, between the ages of 7 and 16, living in Germany. There was a significant decrease in PTSD symptoms from pre-test to 6-month follow-up in the treatment group compared to the control group. The overall symptom severity reduced by 60% within the KIDNET group. In addition, the participants in the treatment group showed significant improvements in intrusions, avoidance and numbing, hyperarousal, and functional impairment. For the waitlist group there were no significant changes except for intrusion. Furthermore, at follow-up only 2 of the 13 participants in the treatment group still had PTSD. However, in the control group 9 had diagnosed PTSD with the other 4 participants presenting with sustained symptom levels on subthreshold levels for a DSM-IV diagnosis. The findings provide evidence that KIDENT can reduce PTSD in refugee children, however, the study has a small sample size and failed to include an active control group.

Peltonen and Kangaslampi (2019)[62] compared the effectiveness of KIDNET with an active control; treatment as usual (TAU). The study comprised of 50 refugee and non-refugee children between the ages of

9 and 17. At post-test, PTSD and psychological distress symptoms decreased for both the treatment groups with a large effect size for NET and small for in TAU. However, this reduction was only significant for the NET treatment group. Interestingly, the greatest change from pre- to post-test was seen in intrusion symptoms in the NET group. While there was a 35% decrease in the number of children who had clinical levels of PTSD in the treatment group, there was only a 10% decrease in the TAU group. This reduction was significant for the former group only. Furthermore, distress was reduced, and resilience improved in both groups. Interestingly, there were no changes seen in symptoms of depression in either group. The authors concluded that there was insufficient evidence to suggest that NET was superior to TAU. However, it does show that NET can be used to reduce PTSD among refugee children. The study had a high attrition rate, and a small sample size. Furthermore, the study failed to assess long-term impact of the intervention on participants. The study also relied on self-reports and was not supplemented with parent-reports.

Limitations of NET

Although research shows promising results for NET, it is not the recommended practice under the 2018 NICE guidelines.[37] However, this may be due to the authors defining children and adolescent as a homogenous group. NET is culturally appropriate for refugee communities as it focuses and reinforces the principles of storytelling.[63] Another limitation of NET is that it is a short-term intervention and may be considered too brief. Furthermore, its body of research conducted with refugee children is limited.[62]

2. Neurotherapy

a. Neurofeedback

Background

Neurofeedback training (NFT) is a non-invasive brain training technique[64] based on the principles of neuroplasticity and operant conditioning[65]. In NFT the individual associates positive and negative brain functions with reward and punishment, respectively[66]. Subsequently, the individual will subconsciously perform positive brain waves to experience rewards. This allows the client to retrain and recondition their brainwaves.[67]

Structure

To measure a person's brain wave, techniques such as electroencephalography (EEG), functional magnetic resonance imaging (fMRI) and low-resolution electromagnetic tomography (LORETA) are used. [68] The non-invasive electrodes record the client's electrical currents from the brain. A monitor is displayed to present the clients real-time brain activity. This 'feedback' on the client's brain activity allows the clinician to compare their brain activity to that of a neurotypical brain.

The client is exposed to visual stimuli and auditory stimuli while the clinician measures their brain activity. When the client's brain acts similarly to that of a 'neurotypical brain' then the client will be exposed to visual and auditory rewards.[66] The rewards may be a brightening of their computer or television screen or a 'hum'. This tells the brain that it is performing in a desired way. The reward will trigger the release of dopamine ('feel good hormone') from the mid-brain to the pre-frontal cortex. Subsequently, if the brain receives positive rewards, then the brain will want to act in accordance with the activity that produces the positive reward and release of dopamine.

Conversely, when the client's brain acts in a way that is far from the desired brain activity then the client will receive visual and auditory punishment (negative reinforcement). This can be a dimming of their

movie and/or an unpleasant sound. This will cause the client to become frustrated. Subsequently, the client will try to find a solution until it produces the brainwave that is desired which will trigger the visual and auditory reward.

The more that the client's brain behaves in the desired way, then the more they will be exposed to the visual and auditory rewards and release of dopamine. Overtime an association between the desirable brain activity and dopamine will be made. Thus, when the visual and auditory rewards are removed, and the brain acts in the desired way it will elicit the release of dopamine. Subsequently, the desirable brain activity will become more frequent (positive reinforcement).[69]

Evidence of Effectiveness

In 2004, The Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) who works under the FASSTT introduced a Neurofeedback Clinic New South Wales[70]. Initially the neurofeedback treatment at STARTTS was delivered to children who were severely traumatised and had failed to make significant progress. However, it has now expanded to adults. The incorporation of neurofeedback alongside psychotherapy resulted in a significant reduction in posttraumatic stress symptoms and considerable improvements in social functioning and school results.

Askovic and Gould (2009)[71] reported on a case study of a 14-year-old refugee child from Africa who had been exposed to multiple traumatic events. The child presented with affect dysregulation. He had reported acts of violent behaviour, disturbed sleep, infrequent night terrors, fear of the dark, sudden mood swings and restlessness. In addition, the client reported problems with attention, concentration, and memory. The client attended 20 twice-weekly sessions comprised of 30 minutes of NFT and 30 minutes of counselling. NFT assisted the participant to recall his painful traumatic memories without becoming hyper aroused or reverting to previously reactive behaviours. The client stated that as a result of NFT he *"became more mature and able to accept responsibility for my (his) behaviour as a grown-up man".* The authors reported a significant reduction in scores for opposition, cognitive problems/inattention, hyperactivity, emotional lability and restless-impulsive, with all the scores below the threshold for clinical significance. The client had improved attention, school performance and less oppositional and uncooperative behaviour and more positive and stable behaviour. The EEG showed an amelioration of alpha excess, highlighting successful activation of the frontal cortex and normalisation of temporal lobe activity. This study shows that NFT and psychotherapy can be used to assist those have previously been unable to make substantial improvements. However, the findings should be taken with caution as it is drawn from a single case study with no control group to make comparisons.

Limitations of Neurofeedback

The main limitation around neurofeedback is the considerable lack of research surrounding its effectiveness on treating trauma among refugees. While there are several studies that show promising results, it is a relatively new approach and therefore not the golden standard for trauma therapy. However, it is recommended for individuals who are not responding to other interventions.[66] Furthermore, there are inconsistencies surrounding the validity of neurofeedback. Neurofeedback is also an expensive, time-consuming benefits are often delayed.[72]

3. Play-Based Approaches

a. Play Therapy

Background

The act of 'play' is imperative for successful and healthy cognitive, physical, and psychosocial development in children.[73] A child between the ages of two and seven will be in 'pre-operational' stage. In this stage, the child will commence using symbols to represent their 'world. As the child's brain continues to develop, their play becomes more complex with the integration of rules. Play can also be used as a creative outlet for children where they can blend imagination with reality. [74]

Play therapy uses the principle of 'play' to assist children with behavioural and emotional difficulties, and achieve optimal growth and development.[75] In play therapy children can express and release emotions that were previously repressed. The therapist assists the child to remodel their maladaptive values or beliefs into more functional ones. They may also help the child to restructure the meaning of their trauma experience and teach the child new coping strategies and defence mechanisms to replace old unhealthy behaviour patterns and assist the child to deal with difficult situations in the future.[76, 77] Play therapy is commonly used with children between the ages of 3 and 12.[73] It is both culturally and developmentally appropriate for refugee children as it allows the examination and expression of thoughts, feelings, experiences, and behaviours without requiring the use words.[78]

Evidence of Effectiveness

A recent study examined the effects of group CCPT among four refugee children aged 8 to 9 from North Korea.[79] The authors reported that after group play therapy the children regained child-like qualities as seen by the decrease in post-traumatic play. In addition, the children regained a sense of control over their negative emotions. The children also learned to follow rules and express themselves in social settings. The group play setting provides a natural environment for children to talk about their experiences and validate one another. Over the course of the treatment, the children were able to provide support to one another. Furthermore, the interaction between one another helped them to understand and regulate their own behaviours and emotions. Despite these positive results, the data was collected through qualitative methods from a small sample size consisting of only females from a single location.

Another form of play therapy is child-parent relationship therapy (CPRT). As the name suggests this model capitalises on the therapeutic power of the parent-child relationship. A case study was conducted by Lim & Ogawa (2014)[80] to investigate the effectiveness of CPRT on a Sudanese father and his 6-years old son. The authors reported a decrease in PTSD symptoms and a reduction in externalising behaviour in the child. Furthermore, through CPRT the father became more open which in turned assisted the child's grieving process through the act of play. The findings from this single case study cannot be generalised to other Sudanese refugees or refugee families. In addition, the authors noted that they modified to the traditional CPRT format to suit the family's needs. Thus, the benefits may be due to the modifications. Another limitation is that while the father reported significant improvements the teachers did not. This raises the concern that these improvements may have been due to the fathers' perception in change rather than his sons actual change in behaviour.

Limitations of Play Therapy

Play therapy is advantageous for children who have limited higher order thinking skills. However, for older children they may be disinterested in engaging in play therapy as they may view it as 'immature'. Thus, it is important for clinicians to choose an intervention that is appropriate for the individual. Furthermore, there is a limited amount of research conducted assessing the efficacy of play therapy in reducing PTSD symptoms on children from a refugee-like background.

b. Supported Playgroup

Background

Supported playgroups, also referred to as facilitated playgroups, differ from traditional community playgroups as it requires a trained facilitator to deliver semi-structured playgroup sessions. The facilitator is trained in early childhood and provides support to families who have specific needs or come from vulnerable communities.[81-83] Supported playgroups aim to improve the development and wellbeing of both the parents and the child.[83]

In the playgroup sessions, the facilitator delivers age-appropriate and culturally sensitive play-based activities to stimulate development.[84] The facilitator has multiple roles. Firstly, to identify developmental delays or issues within the child and refer these families to appropriate services. Secondly, to encourage child-parent bonding through participation in activities. Thirdly, to formally and informally educates the family members on child development, early childhood learning, available resources and provide positive guidance. The facilitator may also invite guest speakers to discuss specific topics based on the community's needs.[83]

Supported playgroups can be delivered in a community centre, at a school or from a mobile van. Mobile supported playgroups have been effective for hard to reach and marginalized families.[85] Save the Children delivered a mobile supported playgroup which to marginalized and hard to reach families who required immediate support.[86] The facilitators assisted families to develop parenting skills, learn to cope with challenges and encourage child development through play.

The types of play activities delivered in supported playgroups focus on three developmental domains: language, social-emotional, cognitive, and physical.[84] Language activities can include storytelling, book reading and nursery rhymes. This helps to develop the way children absorb communication from others and communicate meaning to others. Cognitive activities focus on expanding the children's problem solving, memory and thinking skills. Physical activities aim to develop both gross and fine motor skills as well as balance and coordination through activities such as playdough, water, and sand play.

The socio-emotional skills are primarily developed through group activities. The child is able to learn how identify and deal with their emotions as well as create positive relationships. Furthermore, the child learns to sit, settle, and listen as well as focus and engage in what others are saying or doing. Children also learn to participate, take turns, and observe how other behave and react.

Evidence of Effectiveness

It is common that newly arrived migrants and refugees are physically, socially and/or emotionally isolated which can exacerbate feelings of loneliness. Thus, having a group for parents to socialise and connect with can help reduce loneliness and improve their social lives. In a qualitative study facilitators noted that supported playgroups helped mothers with social isolation.[87] The supported playgroup provided

them with a safe and supportive environment in which they could access services and develop wider social contacts. The facilitators stated that use of modelling in supported playgroups was the *"key approach for helping parents to adopt new behaviours, practices and tactics".* The parents also reported that due to supported playgroup their knowledge and connectedness with their child increased. They also found they were more relaxed and responsive to their children while at home and during playgroup.

Similarly, Jackson et al (2006)[88] found that refugee parents thought the modelling strategies were beneficial and important. The supported playgroup provided refugee children with a predictable, structured, and organised environment where they could play. This is important especially if these children's home life is disorganised and they do not have the toys or freedom to play at home. The activities at playgroup enabled the children to express themselves freely and master new skills at their own pace. The supported playgroup helped to increase their self-esteem, self-efficacy, confidence, and prosocial behaviours as well as reduced shyness. Approximately, four out of the five refugee families observed improvements in their child's moods and behaviours at home. Parents also reported better connections with their children. The facilitators also observed positive social interactions between the parents and children.

In 2012, a qualitative study was conducted to examine the experiences of mothers who attended a Burmese supported playgroup in Perth, WA.[89] The playgroup reportedly became family to the mothers and helped them to develop a sense of community. This was important to them due to the absence of their extended family. The mothers were able to access emotional and practical support from the playgroup facilitators and other mothers. The mothers stated that the formal and informal support they received was *"a highly valued protective resource"* for them. The mothers also noted that playgroup provided their children with the opportunity to socialise and interact with others from their community. The children were taught how to behave appropriately with other children and members. The playgroup allowed the mothers and children to interact with others from their Burmese community which helped to restore the traditions the mothers feared they had lost. The mothers reported that they felt they were able to parent in a way that aligned with their own culture without being judged.

Similarly, New et al (2015)[90] reported that through attending the Burundi supported playgroup the mother's sense of community increased and they were able to develop a social network and meaningful connections with others from their community which they highly valued. The mothers felt that they were able to socialise with other mothers and share their goals and advice. Their shared experiences of being refugees and the difficulties they have faced with their children helped to bring the mothers closer. The supported playgroup provided a strong support network. The playgroup staff assisted them with their emotional difficulties such as stress, anxiety, and loneliness. The supported playgroup also taught the mothers about the school process and expectations within Australia. It also helped the mothers to learn how they could prepare their children for school. For example, reading stories together and teaching their children how to follow rules. Interestingly, the mothers expressed that they lacked the confidence to assist their children due to their limited English and reading skills. However, through the supported playgroup they were able to improve their English skills and in turn their confidence. The research in the literature that has examined the impact of supported playgroups on refugee families rely on qualitative reports and primarily focus on the impact of the supported playgroups on the mothers rather than reporting on the concrete changes it has had on the child.

Limitations of Supported Playgroups

Warr et al (2013)[87] examined the barriers for refugee families accessing supported playgroups. Firstly, refugee parents often feel that playgroups are not a priority for them as they are more concerned

with issues such as food and shelter. Secondly, the concept of pre-school activities or supported playgroups may be foreign to them. Alternatively, the mothers may not be aware that pre-school programs are available. Other barriers that were highlighted included cultural and language differences as well their unfamiliarity of the structure of the program.

Another potential obstacle is the cultural differences between the CaLD participants and the western society. Refugee parents may fear that they are being assessed or that their child will be taken away from them by the authorities. Mclaughlin (2012)[89] found that Burmese mothers felt there was a struggle and conflict between their cultures' way of parenting compared to western society. For example, their authoritarian parenting and, physical punishment and control conflicted with local norms and in some instance's laws. Furthermore, husbands often do not approve of their wives attending due to other husbands being present and/or the view of playgroups as *"usurping"*.

Discussion

This section highlights the significant impact that trauma can have on child development. It also emphasises the need for this population group to receive well considered mental health supports. The review of literature reveals that there is rich information about models of therapeutic support that are effective in supporting traumatised people, however, refugee populations and in particular refugee children are underrepresented.

The review shows promising results that TF-CBT, EMDR and alternative trauma therapies such as NET, play therapy and NFT reduce PTSD symptoms among children from a refugee-like background. However, the literature is scarce, and the referenced studies have notable design flaws. Due to the small number of studies, it was not possible to rank each therapeutic approach based on their level of effectiveness. Further research should be conducted to build on the current literature and compare the effectiveness of the various therapeutic approaches, and their effectiveness for traumatised refugee children.

The purpose of this report is not to recommend that clinicians solely use those approaches highlighted in this review. Instead, this body of work provides clinicians with an overview of current perspectives on evidence-based trauma-informed therapeutic approaches. Rather than rigidly adhering to one therapeutic approach, clinicians who support refugee survivors including children, should consider taking a post-modernistic approach to their work; combining relevant approaches based on their client's presenting needs and symptomology. This would require deep understanding of various therapeutic approaches and an ability to 'read' their client's needs and capabilities in real-time.

Based on the review, it is noted that not only is the available literature limited but so too is the data about the children in this cohort. The data that is available is incomplete and only includes HSP, this significantly underestimates the true cohort and as such service demand cannot be accurately understood.

QUALITATIVE RESEARCH

The literature review explored the theoretical frameworks and best practice for traumatised children. It also examined the impact of western therapeutic approaches on children from refugee background. To compliment this literature review, a qualitative consultation was conducted to gain insight from highly skilled and knowledgeable individuals who have direct experience working with refugee individuals in WA. These perspectives provide a collection of rich and unrestrictive information that quantitative methods as well as literature reviews, may lack. The consultations explored the challenges faced by refugee children, families, and communities and what should be considered with developing services.

Aims and Objectives

Aim

To understand the needs of the refugee community, the challenges faced by community members and service providers, barriers to delivering services, the gaps within the sector and suggestions for the future as well as establishing and rebuilding relationships with communities and agencies.

Objectives

1. Consult with relevant agencies to understand numbers of children in the cohort, current services being delivered, services being delivered in other sectors.
2. Consult with ethnic-community leaders to understand community perspectives on the needs of children, families, and communities and what should be considered with developing services.

Methodology

Sampling

To identify the relevant agencies/organisations the researcher used Google, Refugee Council of Australia, and My Community Directory. The search terms included: *"play group OR supported playgroup AND refugee, asylum-seeker, migrant, CaLD, trauma, and torture and trauma."* Once organisations had been identified they were then e-mailed an invitation to participate in the project. The process of snowballing was then used to increase the sample size.

Participants

Sixteen (16) of the total twenty-six (26) agencies invited, participated in the consultation. Through the use of snowballing, an additional three (3) organisations participated. The final sample consisted of nineteen (19) organisations which equated to thirty (30) stakeholders. A list of the stakeholders is found in Appendix 1.

The sample consisted of highly skilled and experienced workers who have insight into the challenges and needs of children and families from refugee-like backgrounds. The participants have deep connections with refugee people, families, and communities, and drew upon their experiences in the consultations. Research participants considered not just the needs and perspectives of any one specific ethnic or language group but considered the systemic needs of the broad and diverse refugee community in WA. By involving people who have strong relationships with refugees in this research common issues that impact refugee

children could be easily identified as could perspectives on what can be done to shift or improve current services.

Initially, ASeTTS envisioned interviewing its refugee clientele, however, to include these individuals it required more time and planning than could be accommodated in this brief research project. ASeTTS understands the importance of involving the refugee community in creating and delivering programs and therefore will co-design service responses with refugee clientele in the second phase of this project.

Data Collection

Nineteen (19) semi-structured interviews were conducted by the ASeTTS' Evaluation and Monitoring Officer, four (4) of which were conducted alongside the ASeTTS' Chief Executive Officer (CEO). The interviews were conducted face-to-face, via zoom or telephone. The semi-structured interviews ranged from 30 minutes to One hour. A sample of the semi-structured interview guide can be found in Appendix 2.

Analysis

The interviewer recorded notes during the interview process. After the interview, the interviewer re-wrote the notes and included any additional information that was missed. The process of thematic analysis was utilised. This included familiarising with the data, identifying codes, and then finding themes. The themes were reviewed and then defined and named. Once the themes were finalised a final analysis was completed, and the following findings and interpretations were reported.

Results

Eight (8) themes and eighteen (18) sub-themes emerged from consultations with stakeholders. The themes and sub-themes are outlined in Figure 2 and discussed in further detail in the 'Findings and Interpretations' section. In addition to themes and sub-themes, consultations identified the services that were currently available to children from refugee-like backgrounds, this information can be found in the section titled 'Trauma-Informed Services for Refugee Children in WA'.

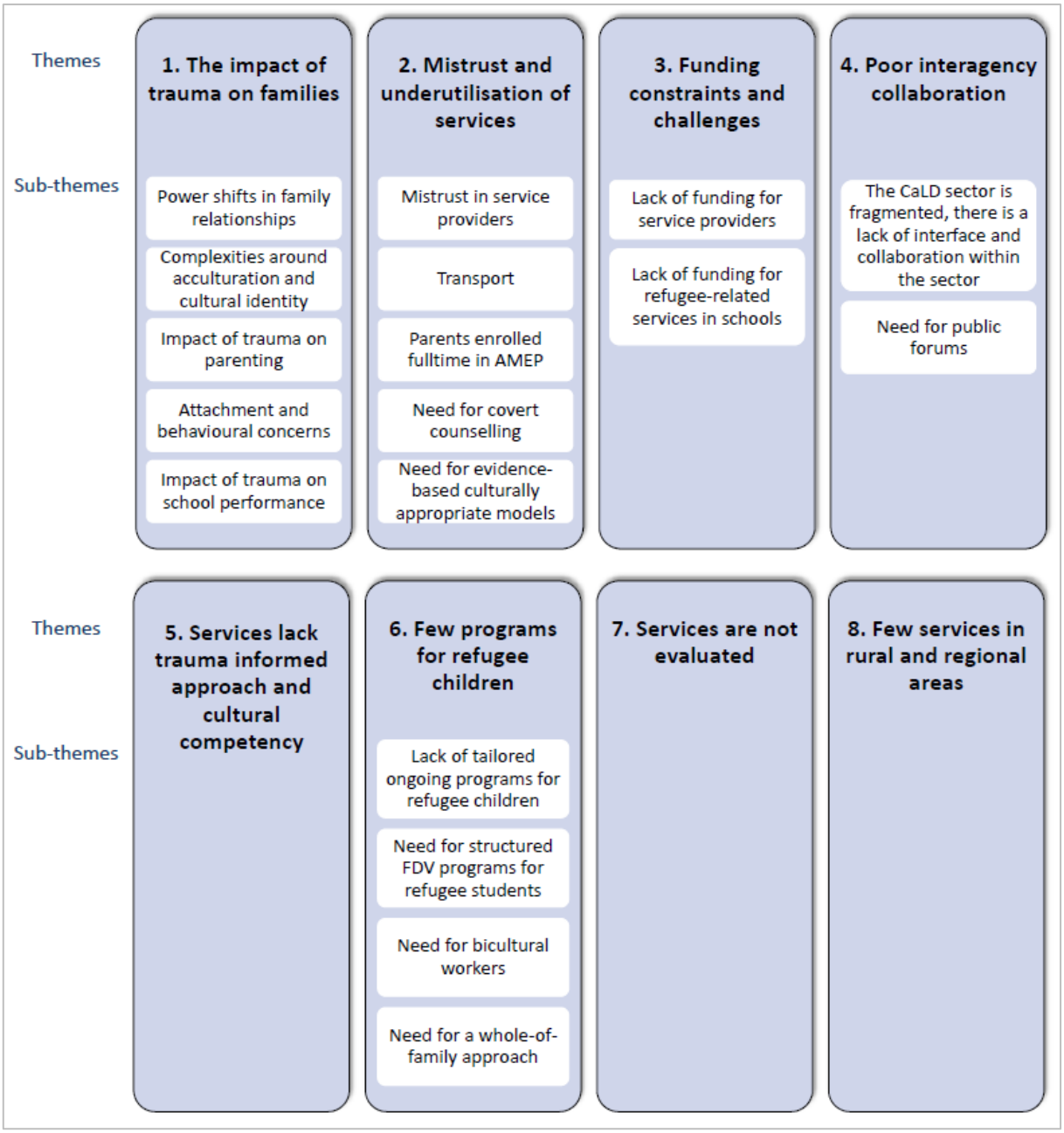

Figure 2. Themes and sub-themes drawn from qualitative interviews

Findings and Interpretations

The following section elaborates on each theme and sub-themes in more detail. Direct quotations have been incorporated in order to support and increase the validity of the findings and interpretations. While this section largely focuses on the consultation feedback there are ties to research that was reviewed in the literature section.

Theme 1. The impact of trauma on families

a. Power shifts in family relationships

Stakeholders consistently reported that many refugee clients not only struggle with the traumas they have experienced in their country of origin and their journey to Australia, but also struggle with the re-settlement process, and the subsequent shifts in power dynamics within their family. One stakeholder noted

that there is often a forced shift in gender dynamics and role expectations between couples as women rather, than men, have increased opportunities to earn an income and support their family. Within many refugee communities and cultures, it is important for men to provide for their family; when they are unable to they can feel disempowered and emasculated. The sense of disempowerment experienced by men is further compounded when their wife receives welfare payments, or when gender roles are reversed. Stakeholder responses were supported by Fisher (2013)[91] whose research outlined that marital relationships and power dynamics were negatively impacted when men from migrant or refugee-like backgrounds lose their role as bread winner, or when their wives begin receiving welfare payments.

The shift in power dynamics between parents and children was also a point for discussion. One stakeholder provided an example of a child from refugee-like background who became resentful and frustrated over regularly being required to translate for his parents who could not speak English. The child could not understand why he was able to learn English and his parents were not capable of doing the same. He expressed that he thought his parents were *"stupid"* and *"dumb"*. This caused the child to see his parents as less capable, knowledgeable, and powerful. This was not an uncommon situation.

A few stakeholders described how refugee children often held greater power within their families than their parents: as a result of their superior English proficiency and knowledge about the Australian legal system. It was noted that children who are aware of their 'power'; often used this as a bargaining tool. For example, one stakeholder referred to a child who advised their parents that they could have them *"locked up"* if they continued to use corporal punishment as discipline. Parents were seen to be aware of the shift in dynamics and discuss with stakeholders that they feel overwhelmed and disempowered because they can no longer control their children. The conversation around inter-generational conflicts and resentment was heavily discussed.

Research by Weine et al (2004)[92] supports the views of stakeholders. They identified that refugee parents who depended on their children, struggled with loss of control over their children and, children losing their culture and native language. Hynie et al (2013)[93] reported that young people believed they had more responsibilities due to their increased knowledge of the host language and culture. They also found that young people struggled to communicate with their parents and experienced issues around their parents' authority and their own freedom and rights. They noted that young people would take advantage of their parent's limited English skills by threatening to call the police if their parents used punitive punishment.

b. Complexities around acculturation and cultural identity

There was broad agreement that refugee children often feel conflicted about adapting to the Australian culture and holding onto their culture and customs. Stakeholders highlighted that *"children often feel caught between the two cultures"* and that children are of the view that their *"parents don't understand"*. They also noted that refugee parents often expressed some trepidation around their child losing their cultural values and beliefs and assimilating to Australian culture. It was noted that the tension of being between cultures creates conflict between parents and children.

One stakeholder commented on how some refugee families have been encouraged by well-meaning service providers to not teach their children their mother-tongue; that this would support children to better assimilate to their host country. Multiple educators that were interviewed, independent of one another, provided examples of families they have supported where the youngest child in the family has only learned to speak English. These children often cannot communicate with their parents and instead rely on older

siblings to translate for them. This dynamic contributes to the child developing insecure attachments with parents and increases the child's confusion about their cultural identity.

c. Impact of trauma on parenting

Trauma can shape the way in which parents communicate and empathise with their child. One stakeholder reported that traumatised refugee parents often *"demonised their children"* and *"stopped seeing them as human beings who are going through their own struggles and problems"*. Another stakeholder, a school psychologist, reported that parents tended to use extreme parenting styles. Some parents would implement restrictive and sometimes unreasonable boundaries and rules, while others provided no discipline or structure.

Many of the parent's stakeholders engage with were understood to be incredibly distressed, overwhelmed, and traumatised. As a result of their stress and distress, children were often inclined to take on the parent/carer role within the family. The additional responsibilities and burdens, have a profound impact on children, increasing their worries and stresses and driving them to be even less like other children of their own age.

A principle from a primary school with a high proportion of refugee children and a multicultural community worker from an IEC school revealed their concerns around parents discussing traumatising themes in front of their children. Teachers are noticing that students are coming to school anxious and worried, talking about the traumatising events that are occurring in their country of origin, which they have overheard from their parents. The conversations discussed by these children has caused other students to also become triggered and traumatised.

Discussions occurred in a number of interviews that parents, particularly mothers, would prioritise their child attending appointments with them to assist them with translation over the child attending school. This was noted as occurring either because parents were not aware of their rights to access independent interpreters, or out of mistrust of translating and interpreting services and their connections within their community or language group. In de-identified examples that were provided the child would in some cases be asked to describe to service providers traumatic events experienced by their parents, for example rape, family, and domestic violence (FDV) or extreme concerns about poverty. The involvement of children in the translation or retelling of traumatic events and/or overhearing adult themes has a strong potential to traumatise, or re-traumatise, the child.

d. Attachment and behavioural issues

When asked what issues refugee children predominantly presented with, the common response was attachment difficulties. The topic of attachment was a part of all stakeholder interviews, from educators, to psychologists, to case workers. It was also noted that refugee children either internalised or externalised their behaviours. One very experienced school principal who supports a high number of refugee students said that students often displayed *"extreme emotions and reactions like anger and sadness"*. They also explained that students often *"feared authority"* and *"are wary to commit to things"*, they also struggled with losing at games and being spoken to in certain tones of voice.

e. Impact of trauma on school performance

Educators and youth workers who were interviewed agreed that school behaviour and performance of refugee children was significantly affected by their families' situation. The more distressed a child is the

more the child's progress in school is impeded. FDV was particularly noted as a growing concern in refugee families and communities that is impacting upon children.

Educators confirmed that the diagnosis of autism was on the rise with refugee children, or they were presenting with autistic traits. There was a view that the lack of available early intervention services, and the lack culturally safe early interventions services, contribute to delays in refugee children being assessed and accessing needed supports. One stakeholder reported that the absence of pre-school assistance leads to refugee children showing developmental delays, and challenges in meeting or exceeding academic expectations.

One stakeholder stressed importance of early intervention to differentiate between acclimation difficulties or an underlying cognitive impairment. They asserted that a refugee child's experience of developmental delay cannot always be attributed to challenges with language acquisition, and similarly challenges in language acquisition are not always as a result of developmental delay. It was noted that over 80% refugee children that were referred to RPH had no underlying cognitive difficulties.

A secondary school teacher said she often found refugee parents and families to be a large barrier in the child's school performance. Parents do not engage in their child's school life this is due to multiple reasons. One of the reasons being that the parents are too traumatised to be able to assist anyone else. Secondly, many parents feel that because they have never learned to read or write in their own language, they believe that they cannot assist their children. Thirdly, parents are uneducated about the Australian Education system and therefore are unaware of how they can contribute to their child's learning. In addition, parents from migrant communities have different beliefs and attitudes around education. Many refugee parents believe that it is the school's sole responsibility to rear their child's academic learning. Parents view teachers as superior and therefore do not engage with them as this would be considered disrespectful. Conversely, in Australia parents often take an active role in their child's learning and school journey.

Multiple stakeholders noted that parents often refused to acknowledge that their child had a developmental delay or cognitive impairment. This was thought to be due to the parents' fear of public or community humiliation, or that it would be a reflection on their parenting capabilities. While this fear resulted in many families disengaging with the educational needs of their child, it had the opposite effect on others; with some parents setting extremely high expectations of their children. A principle explained that some refugee parents place a *"huge emphasis on NAPLAN (National Assessment Program – Literacy and Numeracy)"*. This was thought to be connected to cultural pride and parents not wanting their children to bring shame to their family. A psychologist noticed that where these high expectations are placed on children it has significant impacts on the child's mental health; with children presenting with anxiety and self-harming behaviours.

Interestingly, one English as an Alternative Language/Dialect (EALD) teacher said that from his years of experience children born in Australia who are from a refugee family presented with problems as serious as children who had direct lived experience as a refugee or asylum seeker. This perspective was shared by other interviewed stakeholders; and provides legitimacy to the idea of vicarious and intergenerational trauma.

Theme 2. Mistrust and underutilisation of services

a. Mistrust in service providers

There was a consensus among the stakeholders that available services were often underutilised by refugee families. Several contributing factors were explored by stakeholders, these included:

- Language and cultural barriers
- Limited understanding of service systems and access pathways
- Mistrust of service providers (including interpreters). It was noted that refugee families often refused to use interpreters or translators as they feared that they would talk about their personal information or 'problems' to others in their community. In addition, a Youth Worker from ASeTTS noticed that students often refused to access school psychologist supports due to their pre-existing trust issues.

Services for children were also considered significantly underutilised. Stakeholders outlined that families were often fearful that through participating in services or programs that the Department of Communities: Child Protection would become involved, and issues would be put on their 'record', or their child or children would be taken away. There were concerns that participation would reflect poorly on their parenting skills and bring shame to their family. There were also fears that participation could affect their family's visa status. Such fears resulted in families denying that they were having issues with their child or struggling within the family. Various stakeholders also highlighted the social stigmas within the refugee community, associated with mental illness and disability and other support services.

b. Transport

Transport was presented as another major cause of the underutilisation of services by refugee families. Many refugee parents do not have their driver's license or do not have their own vehicle and rely on public transport. Reliance on public transport results in service attendance rates being significantly reduced in winter.

c. Parents enrolled fulltime in Adult Migrant English Program

Stakeholders revealed that parent's fulltime enrolment in in the Adult Migrant English Program (AMEP) has presented a new challenge for family-focused service providers and programs. The AMEP program provides free English classes to support refugees improve their language skills and settlement into the community; communicate with others in the community and also improve their job prospects. While the value of the AMEP program is recognised, stakeholder, particularly service providers expressed concerns that settlement needs of refugee families are not being met. In addition, children being cared for in creches that are provided by the AMEP may compromise children's development and attachment to their primary caregiver.

d. Need for covert counselling

Several stakeholders suggested that programs should be delivered in a covert manner due to the social stigma attached to parenting supports and mental health in the refugee community. In addition, it was suggested that there are benefits in attaching programs/services with a sports or creative activities. Starting a program or services with an activity that is engaging was considered a fruitful and positive way to introduce concepts such as respectful relationships and positive parenting.

Stakeholder agreed that the title of program or service facilitators was also an important consideration. There was a suggestion for example that there would be benefits in referring to a psychologist or counsellor as a healing person.

e. Need for evidence-based culturally appropriate models

There was a shared understanding amongst stakeholders that when working with children and families from refugee backgrounds, services providers should avoid imposing western models of services. This was seen in the Strength-to-Strength program, where counsellors used a 'post-Milan systemic family therapy principles of care' and noticed that its Western-centric nature was not transferable to refugee families.[94] Refugee families responded to 'more directive and practical advice' rather than the 'abstract and reflective' processes used in the post-Milan technique. Subsequently, culturally appropriate adaptations were made to improve the effectiveness of the program.

There has been much criticism surrounding the transference of western models of mental health/illness on the CaLD community. It is evident that an individual's cultural background can influence their view on mental illness; people's attitudes, feelings and behaviours and the way in which people act and express their mental illness is often influenced by their cultural background. Therefore, diagnosing and treating mental illness should be done in a culturally appropriate manner. Services and programs should adopt models of service that are flexible, adaptive, and culturally safe and appropriate. There is a need to evaluate services not just to understand their effectiveness in an empirical sense but also with regards to how culturally safe and secure they are.

Theme 3. Funding constraints and challenges

a. Lack of funding for service providers

The lack of stable and ongoing funding for services is considered another key barrier to service delivery to refugee children and families. All stakeholders provided examples of the difficulties in providing comprehensive services to children and families in an environment where funding is limited, is available for only a short period, where government agencies dictate what they will fund or support, and where there is limited scope to influence strategic direction of funders or decisions made about areas of government investment.

Stakeholders discussed the impact that limited funding has on client engagement. They noted that service providers are often unable to continuously deliver services to their target population. As a result, services are delivered for periods of time and then quickly retracted. The constant change in available services can be distressing, confusing, and traumatising for refugee families.

b. Lack of funding for refugee-related services in schools

The topic of school funding to deliver services to refugee children was extensively discussed; particularly funding in schools with an Intensive English Centre (IEC). While this is beyond the scope of this project, it is of considerable importance to the overall effectiveness of service delivery in the refugee sector.

One stakeholder described funding cuts in 2013 that resulted in EALD supports being removed from schools. With the absence of EALD supports in schools it was reported that there was a severe breakdown in the relationships between schools and relevant service providers. Schools no longer had the time, resources, or authority to develop deep connections with the families of refugee students, or their wider communities.

These connections were considered very beneficial and important to ensuring the child's engagement in school and facilitating their strong performance.

Representatives from the Department of Education commented on how staff are at capacity and their lack of resources has resulted in only the most severe cases being attended to. In addition to the funding cuts described above, IECs at Koondoola Primary School and Thornlie Primary School had *"huge funding cutbacks especially in terms of mental health roles being significantly reduced".* These cuts have resulted in only three (3) out of the eight (8) IECs having a humanitarian pre-primary program. It was revealed that despite there being available funding for nurses in these schools, there was not funding for mental health related services. Educators also noted that the CAMHS was not structured to provide comprehensive culturally safe services to all refugee children with need; instead, a very discreet team is responsible for service delivery. This team has also been dramatically reduced, which is having a direct negative impact on children, families, and schools.

All stakeholders expressed their frustration around the lack of support available for refugee children, particularly mental health support for refugee students in the school setting. Educators raised concerns that more support is needed for students who are transitioning from *"a safe, IEC, to a mainstream school"*. Representatives from the IEC at Koondoola Primary School provided an example of a former student who advised them that she *"wasn't prepared for high school".* A secondary school teacher noted that due to the lack of early intervention, refugee children are being *"left behind"* and that the impact on this group is *"progressively worsening".* She noted that senior school students are presenting with severe psychological and developmental delays. She also expressed that an increasing number of children are exhibiting with anxiety, depression, and attachment issues and that as a result, students are displaying poor academic performance.

There was an agreement among stakeholders that there was a need to for more coordinated and considered planning and preparation ahead of children transitioning from IECs to mainstream primary schools or to high school. Such planning processes were seen as an important way to prepare the child and the 'new' school and their staff and safeguard the child from potential distress. Schools can use this process to anticipate issues and triggers and implement strategies to provide a safe and nurturing transition for the child. There was understanding that additional resources were required within schools to facilitate these processes and ensure that children are not left behind or further traumatised by the school system.

Theme 4. Poor interagency collaboration

a. The CaLD sector is fragmented, there is a lack of interface and collaboration within the sector

While stakeholders easily acknowledged colleagues in different organisations and agencies, and their contributions to supporting people from refugee-like backgrounds; there was consistent feedback that the CaLD services sector is fragmented and that there is a lack of coordination between and within refugee-related service providers. The lack of cohesion was seen as a function of operating within a funding environment that places providers in stark competition with one another for a limited pool of resources. All stakeholders expressed the importance of developing better collaboration between service providers and openness about the services available to refugee children, families, and communities. This would likely deliver better outcomes for people being supported and reduce confusion or potential duplication of service. Since many refugee clients require assistance from a wide range of service providers, it can be extremely difficult to navigate services. If service providers understand the scope of services and how they

can be accessed, then they can better assist clients to find the services they need and provide warm referral pathways.

Stakeholders unanimously agreed that service providers communicate with one another to collaborate and share and disseminate information and knowledge to ensure that the highest quality of care is being delivered to refugee families.

b. Need for public forums

A number of stakeholders recommended establishing community workshops to improve collaboration and communication between those organisations, agencies and professionals who support refugee children, and refugee community members and leaders. A group from the Education Department agreed that implementing a mental health forum for CaLD, and specifically refugee, children would be beneficial and support workers to remain updated on current issues and available services and provide a platform to exchange resources and information.

One stakeholder outlined the importance of engaging communities and community leader prior to public forums being facilitated, and involving community and language groups in the development, planning and delivery of such forums. There was a view that a meeting of this type would encourage refugee families and communities to more comfortably discuss needs, concerns and provide feedback. Giving refugee families and communities a voice and a sense of control.

Theme 5. Services lack trauma-Informed approach and cultural competency

There was agreement amongst stakeholders agreed that mainstream and other service providers do not demonstrate consistent understanding of cultural needs and differences and are not well informed about the impact of trauma on children. This was considered concerning, particularly where those providers deliver CaLD and HSP focussed services and or health or allied health services. A few stakeholders noted that school leaders and teachers often lack awareness of the impact of trauma on a child's functioning and behaviours and lack awareness of trauma-informed approaches to supporting children. One stakeholder stated that, *"schools are not with it, they are not trauma informed"*. Feedback indicated that mainstream schools struggled with diversity and often were not informed about the refugee experience and therefore were unable to connect with these children. They typically view refugee students as a homogenous group rather than as individuals with unique identities, cultures, and experiences. Stakeholders reported that mainstream schools do not hold nor honour the experiences of children from refugee-like backgrounds; stories and struggles are lost when the students enter mainstream schools.

To demonstrate their perspectives stakeholders provided various examples. In one example, a child who was referred by his EALD teacher to seek support from the school's psychologist. Despite the child's urgent need for support the school psychologist refused to work with the student due to the complexity of their needs, and language barriers. When it was suggested that the psychologist use an interpreter they declined.

In addition, stakeholders noted that teachers were not equipped to support children who may be re-traumatised as a result of current events taking place in their country of origin or in other parts of the world. This gap in understanding recently came to light following events in Afghanistan when the Taliban seized control of Kabul on 15 August 2021, and a humanitarian crisis was declared. Stakeholders reported that as a result of this event they observed a push from teachers and school leaders to become more prepared and

informed about the situation in Afghanistan and how these events impact Afghan children, families, and communities in WA.

Although some stakeholders provided examples where schools lacked cultural competency and trauma-informed practice; it should be noted that there are schools that were seen to be providing good support to refugee children. A principle from a Catholic private school explained how their school uses trauma-informed care. They provided the example that their school has replaced sirens with bells or chimes to prevent triggering their students. They also encourage their students to participate in mindfulness activities. Each classroom has an EALD, and the staff use a *"play-based, enquiry and discovery approach"*. A Youth Worker said that *"Balga IEC do a good job of expressing their students' story and cultural expression"*. A stakeholder said that private schools and public schools with an IEC often had teachers with a higher level of skill whereas mainstream public skills tended to lack teachers with this expertise.

The importance of involving schools in the recovery process was highlighted throughout consultations. A few stakeholders agreed that for this to be achieved schools need to be better equipped to assist refugee children. It was suggested that schools should be provided trauma informed workshops, cultural diversity training and better understand the refugee experience and the impact that this experience can have on wellbeing, development, learning and engagement.

Theme 6. Few programs for refugee children

a. Lack of tailored ongoing programs for refugee children

Stakeholders consistently reported that there is a limited number of structured community service delivered programs available in WA for children from CaLD and refugee-like backgrounds. It was noted that, except for short-term school holiday programs, supports and services for refugee children aged 5 to 12-years are very limited. There was resounding feedback that while short-term school holiday programs provide benefits to children and respite to their families, once the program ends children regress to the pre-program states. There was a shared perspective that children under 12, particularly primary school aged children, would benefit from regular and ongoing engagement in structured programs.

It was noted that many stakeholders referred to models that were *"previously delivered"* and there was limited discussion about new models or ideas for services. It is understood that workers who support refugee children, families, and communities, are stretched, and may not have the time or capacity to keep abreast of changes or developments in delivering clinical services to people from refugee backgrounds; this includes children, adults, families, and community. Service providers who deliver supports to refugee children should encourage and provide their staff and clinicians with time needed to assess and review therapeutic or explore new models of service or novel therapeutic approaches, approaches to understand their effectiveness and impact and determine if they are suitable to be trialled or adopted.

b. Need for structured FDV programs for refugee students

A number of stakeholders recommended implementing an FDV program for refugee children due to the increased prevalence of FDV within refugee families and communities. Again, while this beyond the scope of the project is important in regard to taking a holistic approach.

As previously mentioned, there is a limited number of programs for refugee children and there are currently no FDV-focused programs. Stakeholders agreed that children are not blind or immune to trauma, and that providers need to avoid being overly cautious when working with children from refugee-like

backgrounds. One child psychologist stated that *"to improve the mental health and wellbeing of traumatised children, tough conversations need to be had with the child".* This included tough conversations about FDV.

c. Need for bicultural workers

Building rapport was considered critical to delivering an effective family-based program. It can take service providers a long time to establish strong trusting relationships with service users, this is especially true when supporting individuals and families from a refugee background. Refugee families often fear and distrust authoritative figures including health works (and doctors) who have been known to participate in torture in their country of origin. As a result, their fear and distrust permeate into their host country and subsequently creates a barrier to them receiving services. [36] Stakeholders suggested that service providers establish relationships with communities and their leaders. Stakeholders noted that incorporating bicultural workers has been effective in engaging with target populations. Bicultural workers have a wealth of cultural knowledge and understand the barriers to community engagement and their community's needs. Thus, bicultural workers are able to bridge the two cultures and connect refugee communities in a meaningful way with service providers.

d. Need for a whole-of-family approach

A number of stakeholders agreed that a whole-of-family approach should be taken when providing mental health, wellbeing or trauma-recovery supports to refugee children. An experienced counsellor at ASeTTS suggested that assessments should involve the whole family in order to identify factors within the family that contribute to the child's challenges. They stated that supports should not be provided to the child in isolation, but also the family. It was noted that a child can make progress within the counselling room, but if the family environment and dynamics are not supportive, or if their family life is complicated, then they can easily regress. With this being said, it is often very difficult to include parents, caregivers, and family members in therapy as they often do not wish to engage. While the importance of whole-of-family engagement was highlighted, experienced clinicians and caseworkers also emphasised the importance of taking the time to talk to, and get to know, the child independent of their family. Engaging the child in this way gives insights into their view of 'self' and their identity outside their family.

Stakeholders suggested that parents and/or caregivers participate in parenting programs. Currently ASeTTS does not provide a parenting program for its clientele. However, Relationships Australia deliver the Positive Parenting Program (Triple P) and Women's Health and Family Services deliver the Circle of Security Parenting Program (COS-P) to members from the CaLD community. When discussing the effectiveness of these program with external stakeholders, they stated that from their experience COS-P was more culturally appropriate for the CaLD community than Triple P.

Theme 7. Lack of service evaluation

There is limited evidence that programs being delivered to refugee children in WA, nationally and internationally are being evaluated in a meaningful manner. While most service providers strive to evaluate their programs or services delivered to children from refugee-like background, evaluations were not well planned or considered, were predominantly qualitative in nature, and primarily focused on understanding the impact of programs on parents rather than the child. Organisations typically used ad-hoc and responsive methods. A few stakeholders agreed that organisations should move towards quantitative evaluation methods to examine the efficacy of programs and models of service, or partner with universities to undertake structured evaluations of programs and services. This approach would ensure providers have

robust evidence regarding service needs and demand, and evidence to support the effectiveness of their services. It would also support the sector to share and replicate learnings generate through service delivery and contribute to practical and academic understanding of how best to support people from refugee and CaLD backgrounds and support their families and carers.

Theme 8. Few services in rural and regional areas

All stakeholders highlighted that there is an almost complete lack of services available for CaLD people, and people from refugee-like backgrounds living in regional and rural areas. Services are located in the Perth metropolitan area and centred in suburbs or regions where new arrivals are typically settled. It is generally understood that an increasing number of people and families from refugee-like background are re-settling in rural and regional areas, and that there is a need for service expansion into these areas. However, data that captures this trend is limited and unreliable. ASeTTS is endeavouring to explore regional demand within the coming year.

Discussion

This study is the first of its kind to be conducted in WA. The study employed qualitative techniques to identify and examine the challenges faced by community members and service providers, barriers to delivering services and the gaps within the sector.

The need for this research was broadly recognised and resulted in there being a diverse group of stakeholders contributing to the process. The response to this work research was largely positive. It was however noted that in some consultation's provider representatives were concerned about sharing information about their programs and services, presenting as territorial and threatened. This response is viewed as a symptom of a service environment where funding is scarce, and organisations are required to compete with one another for much needed resources to continue delivering services. Conversely, other stakeholders were enthusiastic about sharing their experiences, successes and achievements and concerns about current services and supports. For some consultation mirrored a counselling session.

Despite the representative services providers, agencies, and advocates each having their own values, purpose, and service priorities; there was a clear shared goal to provide the highest quality of care for refugee clients, families, and communities. While increasing funding may resolve some issues at the coalface, it was not seen as the only solution. For example, the effectiveness of services to refugee children, families and communities cannot be realised in an environment where refugees and asylum seekers experience continued racism in their daily lives (implicit, explicit, and systemic racism) where communities are unwelcoming, or there is a lack of cultural awareness and sensitivity within community to support people from refugee-like backgrounds. People, families, and refugee communities are often reliant on the CaLD and HSP services sector for support in the early years of their transition into Australian culture, this reliance drives the need for the 'sector' to work towards collaboration rather than competition.

There were eight (8) themes and eighteen (18) sub-themes that were drawn from the interviews, which are outlined in some detail in the previous section. While the number of presenting issues were fewer than was originally anticipated, they were very consistently reported by the stakeholders who were consulted. Several of the themes drawn from this study are consistent with research that was reviewed in the literature review. This indicates that, despite having come from different countries cultures and experiences, refugee children and families are experiencing similar challenges. In summary the review of themes and sub-themes highlights the following:

- Where a child has directly or indirectly experienced of torture and trauma, this experience has a significant impact on the entire family.
- Children are not only presenting trauma symptoms from the refugee experience, but factors within their family, and acculturation contribute to their traumatisation.
- Parents and caregivers who are survivors of trauma often struggle in their parenting role, particularly as they navigate changes in culture, gender roles, relationships and positioning within the family; this has a significant impact on the parenting styles and attachment with children.
- Traumatised children from refugee backgrounds often experience extreme emotions and behaviours; this impacts their relationships with others and their school performance.
- While services for refugee children are limited there are a number of obstacles that result in families underutilising those services; this includes: lack of trust in providers, transport challenges, competing priorities for families who are engaged in cultural transition, and social stigma related to certain types of services.
- Limited government funding has an impact on the quality, scope, and continuity of services; it also results in providers competing for resources which stymies collaboration and shared learning.
- The use of trained bi-cultural workers improves engagement with refugee families and communities; this improves the relevance and effectiveness of services.
- Services for children from refugee-like backgrounds should both involve the whole-of-family in a supportive environment to understand family dynamics and factors that impact the child and engage the child independently of their family to understand their sense of 'self.'
- The lack of services in regional areas leaves CaLD and refugee children at risk.

Through undertaking this research, it is clear that there is both a limited number of services for children and young people from refugee-like background, and significant underrepresentation of refugee children in research and literature related to mental health and community service delivery. There is limited empirical research and few opportunities for people supporting refugee children and families to share information about services, outcomes, best practice, and opportunities for development. As a result, current services, or programs for children from refugee-like background are informed by the experiences and viewpoints of specific clinicians and/or service providers rather than the expressed community needs or evidence-base practice. While there is some merit in building upon the wealth of experience and insights of certain providers and practitioners, this approach has risks. For example, there is a risk that the service sector is driven by personalities who may not have kept abreast of changing developments in the field, who may not be open to new perspectives, and may not be sharing their knowledge to develop the skills and practice of newer workers or other providers.

In addition to the above, this research has revealed that service and program evaluations tend to be qualitative in nature and focus on the short-term impact that services or programs for children have on the parents, rather than the child. Findings of evaluations tend to be privately held by the relevant organisation or agency, rather than published or shared with the wider public. This approach prevents shared learning and effectively blocks the continued improvement and development of programs and services delivered to children from refugee-like backgrounds. It creates an environment where providers or agencies do not have

external sources of information or intelligence to draw upon, forcing them to take an insular view of services. This inward-looking approach results in providers and practitioners not naturally considering collaborations and external factors when designing, planning, delivering, or reviewing services, limiting the relevance, usefulness, and effectiveness of services for refugee children and their families. The consultations highlight the need for improved collaboration across providers and agencies without fear of losing 'turf.' They also emphasise the importance of providers, agencies and practitioners improving how knowledge, outcomes, achievements, and learnings are documented and shared. Both at a grass roots level and to inform current literature at an academic level.

While the scope of this research project is broad, the findings confirm that the funds allocated to phase 2 of this project (i.e., service design and piloting), are not sufficient to address all identified issues. As such recommendations for what can be achieved, along with longer term goals and strategic considerations are presented in the Conclusions and Recommendations section of this paper. This body of work has also highlighted that while ASeTTS, the sole provider of torture and trauma rehabilitation services in WA, plays an important role in supporting the mental health and wellbeing of refugee children; they are not the only provider or agency that supports a child through their recovery and acculturation journey. A number of providers play different roles and contribute to the delivery of wrap around supports to refugee children and their families.

Limitations

This research has various limitations. This includes, that although there was a broad call for stakeholders to contribute to this research, there were a number of well-established and experienced CaLD service organisations that declined to participate. As such, the results may be skewed as the full sector is not represented. Secondly, consultation interviews were not recorded. This increases the potential that information may have been missed or misinterpreted. In the future interviews should be recorded and then transcribed verbatim. Finally, the scale of the project resulted in only one individual reading the interview notes and identifying themes; thus, investigator triangulation was not achieved. Despite these limitations, the consultations revealed rich and in-depth findings.

Conclusions and Recommendations

This research was undertaken as the first phase of a two (2) part project which aims to understand and support the trauma needs of children between 3 and 12 years-of-age who are from refugee-like backgrounds and whose parents are survivors of torture and trauma. The aim of this study was to:

1. identify the true scope of services being provided to the target group in WA.
2. develop a more accurate understanding of the number of children and families who would benefit from the pilot program; and
3. identify opportunities to collaborate with or partner with agencies/organisations that either support the target group or who deliver trauma informed services to children and families from other cohorts impacted by trauma.

This project attempted to map the true scope of services being provided to the target group in WA. However, some organisations were unwilling to share information about the projects they deliver. Therefore, the map may not be a true reflection. However, from scoping the sector it is evident that there are limited services being provided to the target group in WA. This highlights a large gap in this area and poses a large concern regarding the long-term impacts this can have of on the children. Phase 2 will endeavour to respond to this need and provide trauma-informed care to children in this cohort.

Another goal was to quantify the population of interest. However, due to the lack of available information online (e.g., government reports) and from various organisations, this was not successfully achieved. Further work is needed to understand the true the number of children and families who would benefit from the pilot program. ASeTTS should directly request reports from government departments and engage with the Department of Home Affairs (DoHA) to expand and build on the data available and reporting methods to overcome the limitations previously mentioned.

Qualitative methods were employed to complete this research, this includes a comprehensive literature review and semi-structured interviews with diverse stakeholders. The research has provided the opportunity to review what is known about supporting children from refugee-like backgrounds who are impacted by trauma, and to conduct a 'stocktake' of current services, their strengths, and limitations. It has also provided experienced practitioners, clinicians, and service providers a forum through which they could share their insights and perspectives; in ways that they are not ordinarily able to. Through this process various issues have emerged, and service development possibilities have been identified. Stakeholder consultations highlighted the various complexities in supporting children and families from refugee backgrounds, and have highlighted the importance of using person-centred, flexible, and adaptive approaches.

The review of research findings has given rise to a range of recommendations. The recommendations which are illustrated in Figure 3 include short-term initiatives which ASeTTS can initiate through the second phase of this project (within 12-months), through to medium and longer-term opportunities, and strategic considerations.

While medium and long-term opportunities and strategic considerations lay outside ASeTTS' scope of influence and the parameters of this project, they have been included in this report as they are considered important, and there is hope that the continued support of government can be garnered to deliver these outcomes over time.

As part of the research undertaken ASeTTS has identified primary schools and service providers that they can partner with to plan and deliver the phase 2 of this project (i.e., the identified short-term service options).

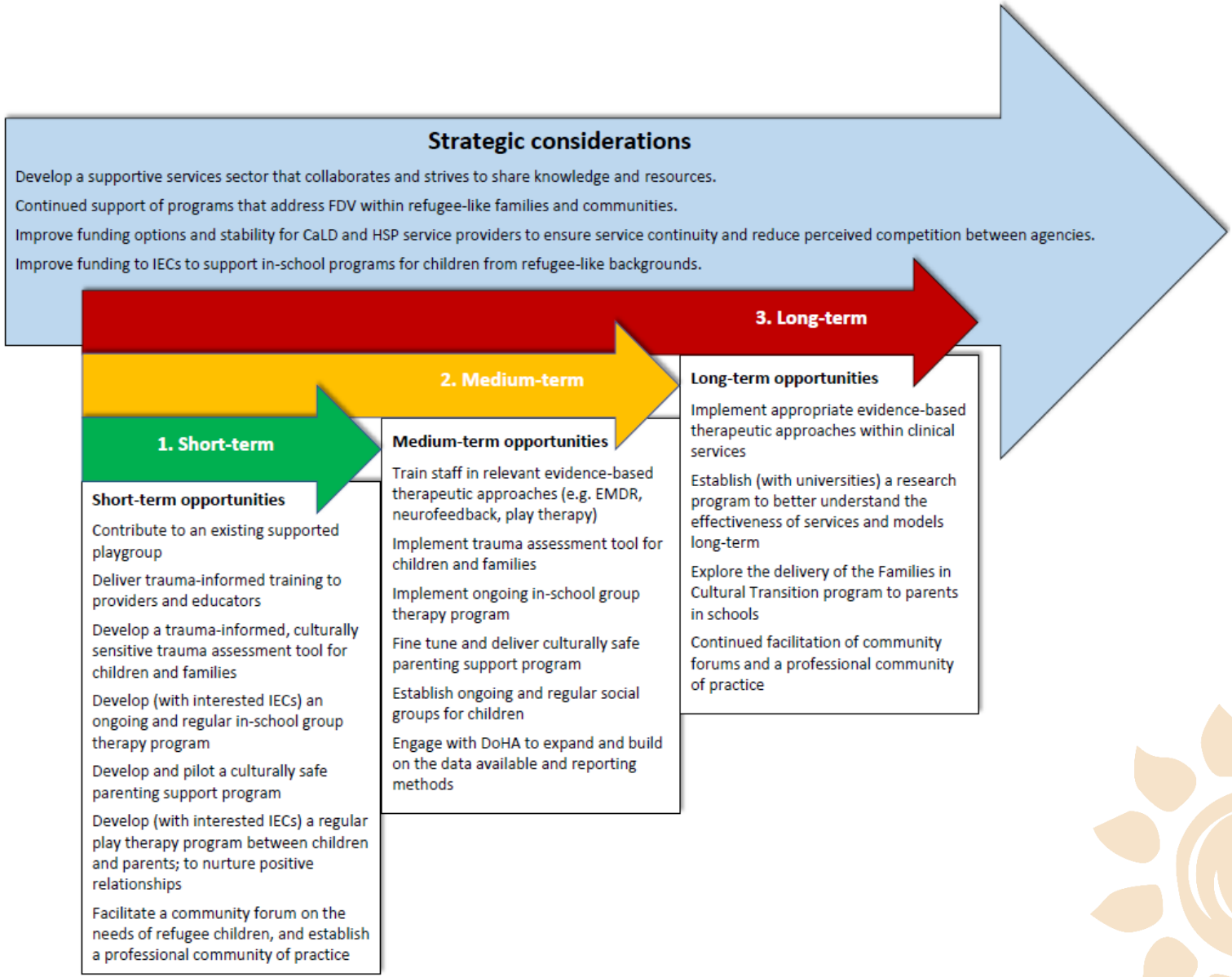

Figure 3. Short, medium, and long-term recommendations

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APPENDIX 1. Stakeholders

Table 2. Stakeholder organisations that participated in qualitative interviews

Organisation
Association for Service to Torture and Trauma Survivors (ASeTTS)
Centre for Asylum seekers, Refugees and Detainees (CARAD)
Edmund Rice Centre Western Australia (ERCWA)
The Department of Education
Gosnells Conference and Migrant & Refugee South Special Works
Ishar Multicultural Women's Health Services
Life Without Barriers
Magic Coat
Majella Catholic Primary School
Mercy Care
Mettamorphosis
Perth Children's Hospital: Child and Adolescent Health Services
Red Cross
Relationships Australia
Save The Children
St Vincent de Paul Society
The Multicultural Communities Council of Western Australia (MCCWA)
The Smith Family
Women's Health and Family Services (WHFS)

**ASeTTS acknowledges the strong opinions and perspectives of the participants interviewed and their deep commitment to their work. ASeTTS also recognises that in the absence of appropriate levels of resourcing or ongoing resourcing that many of those people interviewed have invested their own time, money, and energy into delivering services to refugee children and families.*

APPENDIX 2. Interview Guide

Lotterywest Project Interview Guide

Part 1: Introduction

1. [Introduce yourself and establish rapport]
2. Hello, thank you for meeting with me today.
3. Discuss the purpose of the project

Part 2: Key questions

1. What are the number of children in the cohort?
2. What are the current services being delivered?
3. What other services being delivered in other sectors?
4. From your perspective what are the needs for refugee children, families, and communities?
5. What considerations should be made when developing services for refugee communities?
6. What do you believe we should consider when developing this project?

Part 3: Conclusion

1. Is there anything else you would like to add?
2. [Conclude conversation] Thank you for taking the time to meet with me today

APPENDIX 3. Literature review summary

Table 3. List of articles included in the literature review and a summary of findings

Author	Intervention	Research Design	Control Group	Sample	Aim/Findings
Schottelkorb et al[44]	CCPT	RCT	TF-CBT	N=31 children Age: 6-13 Mixed Ethnicities	Interventions significantly reduced PTSD symptoms in refugee children.
Unterhitzenberger et al[45]	Individual TF-CBT	Case Series	N/A	N=6 Age:16-18 Mixed Ethnicities	Significant decrease in PTSD symptoms.
Unterhitzenberger et al[46]	Individual TF-CBT	Case Report	N/A	N=1 Age: 17 East Africa	Clinically significant reduction in symptoms decreased. Client was no longer considered to be suffering from PTSD.
Unterhitzenberger et al[47]	Individual TF-CBT	Uncontrolled Pilot Study	N/A	N=26 Age: 15-19 Mixed ethnicities	Significant decrease in PTSD and depression.
Oras et al[53]	EMDR	Uncontrolled study	N/A	N=13 Age: 8-16 Mixed Ethnicities	Significant decrease in the means scores from pre-intervention to post-intervention, for post-traumatic stress symptoms, PTSD-related and non-related symptoms as well as symptoms of re-experiencing, avoidance and hyperarousal, and a significant improvement in functioning level, and depressive symptom.
Wadaa et al[54]	EMDR	Non-randomised Control Trial	Refusal Group	N=37 Age:7-12 Iraqi	PTSD symptoms significantly reduced for EMDR group at posttreatment.
Hurn & Barron[55]	Group EMDR	Qualitative Pilot Study	N/A	N=8 Age: 6-11 Libyan and Syrian	Children reported a reduction in disturbance.

Author	Intervention	Research Design	Control Group	Sample	Aim/Findings
Molero et al[56]	Group EMDR	RCT	No treatment	N=66 Age:13-17 Mixed Ethnicities	PTSD significantly decreased at post-treatment for treatment group, however not for the control.
Lempertz et al[57]	Group EMDR	Uncontrolled study	N/A	N=10 Age:4-6 Syria and Afghanistan	Significant reduction in the mean 'teacher-reported total PTSD scores' from pre- to post-intervention and post to 3-month follow-up, all with high effect sizes. Non-significant decrease in mean for 'parent-reported total PTSD scores' from pre- to post-intervention and post to 3-month follow-up.
Banoglu & Korkmazlar[58]	Group EMDR	RCT	Wait-list	N=61 Age:6-15 Syrian	Significant reduction in PTSD and depression and improved wellbeing scores in treatment group compared to control group.
Ruf et al[38]	KIDNET	RCT	Waitlist	N=26 Age: 7-16 Mixed Ethnicities	Significant decrease in PTSD symptoms from pre-test to 6-month follow-up in the treatment group compared to the control group.
Peltonen et al[62]	KIDNET	RCT	TAU	N:50 Age:9-17 Mixed Ethnicities Refugees + non-refugees living in Finland	Total PTSD score reduction was significant for NET group but not TAU.
Askovic Gould[71]	Neurofeedback	Case Study	N/A	N=1 Age=14 Africa	Significant reduction in scores for opposition, cognitive problems/inattention, hyperactivity, emotional lability and restless-impulsive, with all the scores below the threshold for clinical significance.
Kwon & Lee[79]	CCPT	Uncontrolled study	N/A	N=4 Age:8-9 North Korean	Decreased posttraumatic play and regaining childlike qualities.

Author	Intervention	Research Design	Control Group	Sample	Aim/Findings
Lim & Ogawa[80]	CPRT	Case Study	N/A	N=1 Age: 6 Sudanese	Decreased parental stress and child's externalizing behaviours.
Warr et al[87]	Supported Playgroup	Semi-structured interviews	N/A	N=14 Community coordinators supported playgroup Facilitators Local health workers Mothers/Carers who attended	Explored the impact of supported playgroup on parents and children from non-English speaking backgrounds.
Jackson [88]	Supported Playgroup	Semi-structured interviews	N/A	N=16 Refugee carers and their children Playgroup facilitators	Investigated the usefulness of supported playgroup in supporting refugee family needs.
Mclaughlin[89]	Supported Playgroup	Focus groups and semi-structured interviews	N/A	N=9 Burmese refugee mothers	Examined the lived experiences of parenting amongst a group of Burmese refugee mothers in a facilitated playgroup.
New et al[90]	Supported Playgroup	Focus group and interviews	N/A	N=8 Refugee mothers Burundi	Explored the experiences of African refugee mothers in relation to their children's school readiness and transitions to school, and the ways one supported playgroup assisted them in this context.

APPENDIX 4. Advantages and limitations of identified trauma-informed therapies

Table 4. Advantages and limitations of identified trauma-informed therapies

Intervention	Advantages	Limitations
Trauma-Focused Cognitive Behavioural Therapy (TF-CBT)	• In addition to EMDR, is the leading evidence-based trauma treatment • Child-specific intervention • Effective in reducing PTSS in children and adolescent • Research to suggest it is more effective than EMDR for children and adolescent – however evidence not sourced from study using sample of solely refugee children • Adaptable to a group format • Requires more sessions that EMDR • Parental involvement is voluntary	• Highly structured • Talk-based • Requires ongoing commitment from client • Initial feelings of being more anxious/emotionally uncomfortable • Focuses on current issues • Requires homework • Requires more sessions than EMDR • Limited research and evidence supporting its effectiveness among refugee children
Eye Movement Desensitisation Reprocessing (EMDR)	• In addition to TF-CBT, is the leading evidence-based trauma treatment • Effective in reducing PTSS in children and adolescent • Not-talk based • Adaptable to a group format • Requires less sessions than TF-CBT	• Limited research and evidence supporting its effectiveness among refugee children • Lack of parental involvement • Parental reports show less improvements in child behaviour than TF-CBT
Narrative Exposure Therapy (KIDNET)	• Child-specific intervention • Literature shows promising results • Adaptable to a group format • Parental involvement is voluntary	• Highly structured • Short-term treatment intervention (considered too short) • Talk-therapy • Less empirical evidence compared to TF-CBT and EMDR • Limited research and evidence supporting its effectiveness among refugee children
Neurofeedback	• Useful for children with severe trauma symptoms and/or not responding to other techniques	• Expensive • Time-consuming • Delayed improvements

Intervention	Advantages	Limitations
	• Improvements in patients with ADHD, schizophrenia, insomnia, learning disabilities, ASD, depression, anxiety, pain management • Safe and non-invasive • Research shows promising results	• Limited research and evidence supporting its effectiveness among refugee children and wider population
Supported Playgroup	• Group offers normalization of trauma-related impact for parents and child • Provides a safe and structured environment for children and parents • Literature shows promising results	• Parent involvement is required • Parents may feel that they are being assessed/judged • Limited research and evidence supporting its effectiveness among refugee children • Maximum ten children per group
Play Therapy	• Does not require verbal language • Provides a safe and structured environment for children • Non-threatening approach to recall trauma memories • Adaptable to a group format • Parental involvement is voluntary • Literature shows promising results	• Less empirical evidence compared to TF-CBT and EMDR • Limited research and evidence supporting its effectiveness among refugee children

APPENDIX 5: Suitable ages for proposed therapeutic approaches

Table 5. Suitable ages for proposed therapeutic approaches

		Age									
		3	4	5	6	7	8	9	10	11	12
Intervention	Supported Playgroup	X	X	X							
	TF-CBT			X	X	X	X	X	X	X	X
	EMDR					X	X	X	X	X	X
	KIDNET					X	X	X	X	X	X
	Neurofeedback				X	X	X	X	X	X	X
	Play Therapy	X	X	X	X	X	X	X	X	X	X

APPENDIX 6: Developmental stages for children between 3 to 12 years-of-age

Table 6. Developmental stages for children between 3 to 12 years-of-age

Developmental Theory		**Age**									
		3	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Piaget's Stages of Cognitive Development		**Pre-operational**				**Concrete Operational**					**Formal Operational**
Erikson's Stages of Personality Development		**Initiative vs Guilt**		**Industry vs Inferiority**							**Identity vs Role Confusion**
Kohlberg's Stages of Moral Reasoning	**Level 1: Pre-conventional *Stage 1* *Punishment-obedience Orientation***	X	X	X	X						
	Level 1: Pre-conventional *Stage 2* *Instrumental-hedonistic Orientation*			X	X	X	X	X			
	Level 2: Conventional Morality *Stage 3* *Good-child orientation*					X	X	X	X	X	X
	Level 2: Conventional Morality *Stage 4* *Law-and-order orientation*								X	X	X
	Level 3: Postconventional Morality Stage 5 Social-contract orientation										X