At the end of 2008 the United Nations High Commissioner for Refugees (UNHCR) estimated that there were 10 million refugees around the world and over 14 million internally displaced persons. Many more were deemed stateless (over 6 million), with a total of 34 million “of concern” to the agency. Around one-third of these persons were children aged 6–17 years, and around 10% were less than five years of age. Infants and children constitute a significant proportion of those impacted by war, conflict, displacement and loss and are among the most vulnerable.

The developed world maintains a clear approach aimed at regulating and limiting the influx of asylum seekers and there remains community concern about the impact of new arrivals on employment, standard of life and cultural values. The term *multiculturalism* has become highly charged for some nations and also highly politicized. Pressure increased during the 1990s with increasing numbers of displaced persons seeking asylum in response to war and mass violations of human rights (UNHCR, 2000). Many had experienced torture, sexual assault and other trauma and presented with a range of health and mental health issues. Children have been both witness to and direct victims of atrocity (Murthy & Lakshminarayana, 2006).

In spite of the overwhelming needs of asylum seeking people the majority of industrialized countries have no formal resettlement programs with the result that millions of people seek asylum directly with some entering countries in an “unauthorized” fashion (around 5 million from 1995 to
Humanitarian protection programs are limited with many refugees spending protracted periods in refugee camps and being further exposed to deprivation and trauma. The main response of many rich nations has been to develop so-called policies of "deterrence," including increasing border protection measures and limiting rights to appeal (Silove, Steel, & Walters, 2000). In some countries, particularly Australia, asylum seekers have had limited access to health care, education and work rights. These restrictive measures directly impact the welfare, development, and health of infants and children and have been particularly controversial.

Perhaps the most controversial measure introduced in some countries has been the detention of asylum seekers, including women, infants and children. The United States, United Kingdom, Germany, Italy, and Australia have all detained significant numbers of children as routine practice despite concerns about the nature of detention environments and difficulties providing child support, activities, and education. The practice of detaining children, including unaccompanied minors as well as those with family groups, seems to be in conflict with the statements of the UNHCR that detention of children should only be used as a measure of last resort and for short periods of time. The housing of family groups in immigration detention facilities creates specific management difficulties and raises issues as to how best to protect the human rights of children in this situation. In the United States more than 5,000 children are held in immigration detention on an annual basis and in 2006 a 512-bed facility purpose built for the detention of families was opened in Texas. The British government has formally submitted a reservation to the UNHCR seeking to enable children subject to immigration control to be excluded from human rights provisions (Newman & Steel, 2008). Australia was the first developed nation to develop a policy of mandatory detention for all "unauthorized" arrivals and allowed this for an indefinite period time (Silove, Austin, & Steel, 2007). Detention of children has highlighted what may be seen as a fundamental tension between the priorities of immigration law and the rights of children to care and protection.

Although voluntary signatories to the United Nations Convention on the Rights of the Child, it is arguable that several countries stand in breach of this and related conventions in an ongoing way. In Australia, for example, the use of a remote facility for processing of asylum seekers on Christmas Island, in effect detains all child asylum seekers and does not allow for community detention placements of families with infants and children (Newman, 2009). In the midst of debates about the appropriate response to asylum seekers, infants and children have become caught in a system that is unable to provide adequate protection or support for those who have already experienced significant trauma. The following discussion will review the psychological and developmental impact of immigration detention on child asylum seekers, with reference to the Australian experience and research findings.

SEEKING ASYLUM, DETENTION, AND MENTAL HEALTH

Between 1999 and 2005 around 3,000 children were held in immigration detention facilities in Australia. The average length of stay in 2003 was around 20 months. Significant numbers of unaccompanied minors, mainly adolescent boys, were also detained. Detention facilities were in remote regions with little provision for the health and mental health needs of detainees, and in particular, limited facilities for children and inadequate play and educational services—in effect, a neglectful environment. In addition to environmental and emotional deprivation, children were also impacted by the experiences of their parents/caregivers, many of whom developed significant depression. The dilemma for many asylum-seeking parents is that many have fled their country of origin motivated to protect their children, only to find themselves in a detention environment. The capacity of parents to manage their own trauma and distress is of primary importance on mediating the effects of traumatizing or depriving environments on infants and young children. The traumatized parent may find it difficult to provide a "buffer" or protective function for their child if they are overwhelmed by their own experiences.

For many parents in immigration detention experiences of depression and guilt are common. Rates of depression, anxiety, trauma-related and physical symptoms increase with the length of time spent in detention (Green & Eagar, 2010). Witnessing the deterioration of a parent's mental functioning may have particularly negative impact on children as described in observational studies to have high rates of regressed behaviors, anxiety and attachment difficulties (Mares, Newman, & Dudley, 2002). Over 80% of adult detainees have been found to meet diagnostic criteria for depression and related mental disorders (Steel et al., 2004) suggesting that the impact on their children will be major. Mares and Jureidini (2004) report on a diagnostic survey of asylum seeker children in Australia and found that all 10 children aged 5 to 7 years had cognitive delay and that all children aged 7–17 years met diagnostic criteria for posttraumatic stress disorder and major depression with suicidal ideation. Significantly all these children had experienced further trauma while in the detention environment and were witness to riots, behavioral disturbance, and self-harm.
VULNERABILITY, RISK, AND PROTECTION

Child asylum seekers are particularly vulnerable to the impact of trauma. The outcome for these children reflects the impact of premigration trauma, the detention experience and the response of adult caregivers. Parenting and child protection are fundamentally compromised in traumatic environments (Newman & Steel, 2008).

Two particularly vulnerable groups of child asylum seekers are those born in detention and those unaccompanied minors seeking asylum having arrived alone. Infants have clear neurodevelopmental vulnerability and sensitivity to disruption of caretaking relationships and emotional interaction. Reports of pregnant asylum seekers in the United Kingdom describe women with anxiety during their pregnancy, later concerns about infant development and lack of confidence in themselves as parents. Women described feelings of guilt and shame at having an infant in detention and were concerned that their infant would be psychologically damaged (Mcleish, Cutler, & Stamer, 2002).

Unaccompanied children and adolescents experience not only the trauma of forced migration but the burden of responsibility for the continuity and survival of their family and culture. In addition they are separated from parents or adult caregivers and significant numbers are orphaned. These children may have been directly targeted in their home countries and involved in war conflict and forced labor. The risks for unaccompanied child asylum seekers in terms of sexual exploitation and trafficking are significant. Identification of unaccompanied and separate children remains problematic and children may not have appropriate explanations or legal support in the process of seeking asylum (Bhabha, Crock, & Finch, 2006). Failure to recognize child-specific persecution (such as sexual abuse and forced marriage and female genital mutilation), results in underresponse to trauma and increases the risks of ongoing psychological disorder. A major issue within detention settings is the lack of child specialist mental health expertise and limited capacity to recognize signs of trauma or distress in children.

Extreme stress in child asylum seekers has been described as contributing to a severe withdrawal resulting in children feeling utterly helpless in their situation, frequently with overwhelmed parents (Bodegard, 2005). These children present with withdrawal, mutism and refusal to eat or drink requiring hospitalization. A highly publicized case in Australia raised significant concerns about the need to protect children even in the face of the impact of immigration law.

The case of S.B., an Iranian child held in detention with his family, initially in Woomera and then Villawood detention center in metropolitan Sydney, received extensive publicity and put the issue of child detention on the public agenda (Moorehead, 2006). S.B., aged five years, spent a period of 11 months in the Woomera detention facility in a remote Australian desert and was exposed to riots, self-harm, suicidal behavior, and violence. He became progressively more withdrawn and anxious, had nightmares, and started bedwetting. The family was transferred to Villawood detention center in Sydney, where the child was again exposed to behavioral disturbance and self-harm. He witnessed a significant suicide attempt and became progressively more withdrawn and mute. His condition deteriorated to the point that he refused to eat or drink, and he was admitted to the hospital on several occasions for dehydration. He showed some improvement each time he was admitted to the hospital but relapsed each time he was returned to detention. Several child psychiatrists and other professionals advised that S.B. should not be returned to detention and urged that he be released into the community along with his mother. This advice was neglected by the then Minister for Immigration, who argued that to do so would set a precedent for the release of other children. S.B.'s condition continued to deteriorate, and after six months in Villawood he was removed from his family, again against professional advice, and placed in a community foster care. His mother was released four months later, and his father eight months after that, when he was found to be a genuine refugee and granted a residency visa. At 12 years of age, S.B. remained under psychiatric care and had ongoing features of posttraumatic stress disorder, depression, and adjustment difficulties.

PROTECTING CHILD ASYLUM SEEKERS

Several United Nations committees and international nongovernment organizations have reported on the negative impact of immigration detention and particularly the mental health and developmental consequences. All reports have found that the prolonged detention of vulnerable groups is damaging to mental health and is directly related to the high prevalence of mental disorders found in these groups (see HREOC report). Community concern and advocacy on behalf of child asylum seekers in Australia, and increasing concerns about mental health issues in detention centers, gave impetus to some reforms in detention operations and a stated policy of avoiding the detention of children and families. In practice, the policy of off-shore (Christmas Island) housing of asylum seekers has negated this positive initiative.
The need to protect children and prevent mental health problems has created a complex situation where advocacy is a central component of the clinician's role and this may bring clinicians into conflict with government policy (Newman, Dudley, & Steel, 2008). In Australia there has been a discussion about the primacy of immigration law over child protection concerns and an ongoing need to advocate for the removal of children and their attachment figures from remote facilities. For clinicians significant ethical dilemmas present themselves—to work within or outside detention centers; how to treat when the environment and operations of detention are contributing in a major way to the disorders; and whether to engage in a highly politicized arena. Many child mental health clinicians are familiar with the need to advocate for children and their services, but not many have needed to learn the skills necessary to engage in a political process. Detained asylum seekers will inevitably experience some level of distress related to their situation and will deteriorate in situations of prolonged detention. Psychiatrists and mental health professionals have limited capacity to treat in this situation, but arguably have a greater role in raising concerns and awareness about a situation where human rights are violated (Dudley & Gale, 2002).

CONCLUSIONS: TRAUMA AND RECOVERY

Trauma on a massive scale, such as that experienced by many asylum seekers, raises challenges for traditional (Western) psychological models of adaptation and recovery. The term trauma in psychological theory usually describes individual internal responses. For asylum seekers trauma has been a collective experience and it often has a long history. Trauma of this type may involve multiple issues and threats to culture and meaning (Miller & Raso, 2004). Responding to the individual's distress remains important but the cultural, political and historical meaning provide the context. In these situations, the survival of the child asylum seeker comes to symbolize the future continuity of the community and culture. The risks asylum seekers take to provide a future for their children are considerable.

Recovery from trauma and humanitarian crisis as described by Silove and Steel (1999), involves an involved process of reestablishing safety, security, and relationships. For children provision of and connection with attachment figures and consistent care is central to processing of trauma. Supporting parents in regaining a sense of parenting competence will also be important.

In the longer term, child asylum seekers need support to piece together a narrative account of their history of flight and resettlement, and to come to terms with the many losses they and their family have experienced.

Clinicians have a central role in this process, but also in advocating for the rights and welfare of children trapped within systems of deterrence and inappropriate detention.

REFERENCES


