***The impact of immigration detention on children: A systematic literature review***

Dr Felicity Brown, Dr Elizabeth Beadle, and Dr Justine Evans- on behalf of Psychologists for Humane Asylum Seeker Treatment (PHAST).

We are a Brisbane-based group of psychologists and researchers advocating for the humane treatment of asylum seekers who attempt to seek refuge in Australia. Understanding that several submissions will be received by the commission detailing first-hand accounts of experiences in immigration detention centres and there impact on children, we sought to offer something different. We conducted a systematic literature search of empirical studies addressing this question. The review, which is presented below, highlights the paucity of research in this area. Given that the small body of literature that exists for children points to highly detrimental outcomes, we argue that detention of children in immigration detention centres is not in the best interest of children, and has the potential to cause significant harm on both short-term and long-term developmental and mental health outcomes.

**Introduction**

 An estimated 45.2 million people worldwide have been forcibly displaced due to conflict, persecution, violence, or human-rights violations1; 15.4 million are refugees seeking protection outside their home country1, and approximately half of these are children and adolescents2. Australia ranks third in terms of refugee resettlement countries, granting approximately 20,000 humanitarian visas in 2012-20131,3, and has an international obligation to facilitate beneficial physical and psychological outcomes for these individuals1.

 There is documented evidence that asylum-seekers, displaced people, and refugees demonstrate high levels of pre-migration trauma, psychological distress and disorders compared to non-refugee groups, and therefore may be considered a vulnerable population4-6. The experience of detention has also been found to put asylum seekers at higher risk of developing mental health problems than asylum seekers who are processed in the community, with increasing severity of psychological distress associated with length of time spent in detention7. Post-migration stressors can also exacerbate existing difficulties8,9.

 Since Australia initially introduced mandatory detention provisions in 1992 (requiring that all persons entering the country without a valid visa, including asylum seekers, be detained until their refugee status was determined), a number of health professionals and Commissions of Inquiry10-12 have expressed concerns about the detrimental effects of detention on psychological well-being, particularly of individuals pre-exposed to trauma. According to the latest Department of Immigration and Border Protection statistics, as at 30 April 2014, there were 4258 people in immigration detention facilities, 833 of these children. This report seeks to determine the potential psychological impact on these children based on the scientific data available.

**Method**

***Objectives***

The primary objective of this systematic review was to summarise the available published evidence on the level and nature of internalizing or externalizing symptoms and psychiatric diagnoses in children who have been placed into detention.

***Search strategy***

A systematic literature search was conducted on the following electronic databases for the period January 1992 to May 2014: CINAHL, PsycINFO, PubMed, and Embase. Search strategy was tailored for each specific database. The searches used exploded Medical Subject Headings or equivalent where relevant, and the following four sets of keywords combined with the Boolean operator ‘AND’:

1) Patient group: child or children or youth\* or adolescent\*

2) Patient group: refugee\* or asylum-seeker\*

3) Intervention: Detention\* or Immigration-detention\*

4) Outcome: behaviour\* or behavior\* or stress or anxiety or anxiety symptom\* or anxiety disorder\* or depression or depressive symptom\* depressive disorder\* or child behaviour\* or child behavior\* or behavioral symptom\* or behavioural symptom\* or emotion\* or suffering or trauma\* or traumatic-stress or traumatic stress\* or post-traumatic stress\* or post traumatic stress\* or PTSD or “trauma symptoms” or

 suicid\*.

 Searches were limited to papers listing use of human subjects, and written in English. Reference lists of included studies, as well as the excluded commentaries and letters, were manually searched for any further relevant studies.

***Inclusion criteria***

Studies were eligible if they met the following criteria:

1. Reported on child subjects (aged up to 18), either currently detained or previously placed in detention or removal centres in any Western, high-income country.
2. Reported qualitative and quantitative data on internalizing or externalizing symptoms. Qualitative studies that described consecutive case series of more than two cases were included.

Studies were excluded if they:

1. Reported on an adult sample only, or did not provide separate outcomes for child versus adult participants
2. Consisted only of a single case study
3. Did not contain original data (e.g. commentaries and letters).

Two reviewers independently screened the abstracts and titles of the full search yield for inclusion. Two reviewers then independently reviewed the full texts of potentially eligible studies to determine whether they met inclusion criteria. There was 100% agreement for inclusion/exclusion of each study. Data was systematically extracted and collated.

**Results**

 As shown in Figure 1, a total of 62 unique articles were initially identified from the search process across the four databases. Of these, 24 were excluded on the basis of title and abstract, and a further 24 were excluded from examination. Full text examination of the remaining 38 articles resulted in only 4 articles being included in the review. Table 1 outlines the characteristics and findings of these studies.

Articles found through systematic searches and screened on basis of title and abstract by 2 reviewers (n = 62)

Articles excluded (n = 24)

Reasons for exclusion:

* Ineligible population (n = 13)
* Ineligible outcomes (n = 7)
* Ineligible intervention (n = 4)

Articles retrieved for detailed full text examination by 2 reviewers (n= 38)

Articles included (n = 4)

Articles excluded (n=34)

Reasons for exclusion:

* Ineligible population (e.g. not children; n = 8)
* Ineligible outcome (e.g. not mental health or development; n = 3)
* Single case study (n = 6)
* Commentary or review (n= 17)

**Figure 1.** Flow diagram of search strategy of systematic review

**Table 1:** Characteristics and Findings of Included Studies

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Authors/****Country** | **Sample characteristics & setting** | **Origin of sample** | **Detention status** | **Design** | **Child Specific Measures** | **Key Findings** |
| Steel et al. (2004); Australia | n = 10 families, including 14 adults and 20 children; child age range =3 – 19 years; detainees; Average period detention = 2yrs 4 months;  | Not disclosed | Current | Cross-sectional (looked at current and lifetime disorders) | K-SADS-PL;  | All children were diagnosed with at least one psychiatric disorder while in detention; 80% diagnosed with multiple disorders; 10-fold increase in prevalence compared to pre-existing disorders.  |
| Mares & Jureidini (2004); Australia | n = 36 families, including 16 adults, detainees; 20 children; child age range = 11months – 17years (10 able to be interviewed for psychological assessment between 6 – 17years old);  | Iran, Iraq, Afghanistan, Palestine | Current | Cross-sectional (qualitative follow-up) | Clinical interview for diagnosis | All children interviewed met criteria for PTSD & depression; Anxiety, enuresis, somatic symptoms, self-harm also reported; All children had at least 1 parent with mental health problems;  |
| Lorek et al. (2009)U.K. | n = 24 children; detainees; child age range 3months to 17years (11 able to be interviewed for psychological assessment between 3 – 17years old);  | Nigeria; Uganda; Central African Republic; Jamaica; Congo-Brazzaville; Demographic Republic of Conga; Ghana; Pakistan; | Current  | Cross-sectional  | Semi-structured clinical interview for diagnosis; SCAS; DSRS; R-IES-13; SDQ; | Clinical interviews: All children were diagnosed with at least one psychiatric disorder;Parents reported 10/11 children experiencing significant emotional symptoms; peer problems, conduct disorder also reported; All older children (n = 6) reported significant depressive symptoms; anxiety also self-reported;  |
| Deans et al. (2013); Australia | n = 146 children (Total 770 adults and children); detainees being reviewed in a public hospital;  | Most common: Iran; Afghanistan; Iraq; Indonesia; Sri Lanka;  | Retrospective | Cross-sectional  | Clinical interview for diagnosis | Most common primary diagnoses: musculoskeletal problems (36.3%), respiratory problems (11.6%), infectious diseases (9.6%). Psychiatric presentations were reported in 13.7% of cases. |

***Sample characteristics***

Steel and colleagues13 and Mares and Jureidini14 both sampled 20 detained refugee families in Australia, sample age ranges were 3 to 19 years old and 11 months to 17 years old respectively. Lorek and colleagues15 sampled 24 children (aged 3 to 17 years old; parents present during assessment) detained in a British immigration detention centre. Deans and colleagues16 collected statistical data on detainees being reviewed in a large metropolitan public hospital in Australia. Data were collected from 146 children.

***Study design and methodology***

 Steel et al.13, Mares and Jureidini14 and Lorek et al.15 all utilized structured clinical interview methodology for the assessment of psychiatric symptomology. Measures used were those typically used in the assessment of child and adolescent psychiatric symptomology including: Schedule for Affective Disorders and Schizophrenia for School-Age Children – Present and Lifetime Version (K-SADS-PL); Spence Children’s Anxiety Scale (SCAS); and Strengths and Difficulties Questionnaire (SDQ). Deans et al.16 utilized retrospective chart review to identify primary and secondary reasons for presentation to hospital. The studies largely only used cross-sectional methodology. Only one study14, reported follow-up data, however this data consisted of only qualitative comments rather than full repeated assessment of outcomes.

***Impact of detention on children and adolescents***

Mares and Jureidini14 had experienced mental health clinicians conduct a series of clinical interviews with consecutive referrals of detained children referred to a public mental health assessment and treatment service. These interviews were conducted over time to ensure consensus diagnosis on the children assessed. The study found that developmental delays were common in children aged less than 5 years. Half of the sample had delays in language and social development. Additionally, emotional and behavioural dysregulation as well as attachment problems were present. All children aged 6 to 17 years (n = 10) fulfilled criteria for PTSD and major depression with suicidal ideation. Eight children (80%) had engaged in previous acts of self-harm. Seven (70%) had symptoms of anxiety disorders and 50% had persistent physical health symptoms. At least one parent of all children had a diagnosable psychiatric disorder. The authors qualitatively noted that the mental state of the children and families assessed deteriorated during the treatment period.

 Steel et al.13 found that amongst children held in detention for a minimum of two years, 100% met diagnostic criteria for at least one psychiatric disorder, including major depression, PTSD, separation anxiety disorder, enuresis, and oppositional defiant disorder. About half the children described suicidal ideation, and a quarter had engaged in self-harming behaviour. Additionally, the study found that the prevalence of psychiatric disorders increased markedly during the period of detainment. The authors reported that retrospective assessment of pre-detention symptomology suggested low levels of psychiatric disturbance before arrival in Australia, prevalence of disorders increased 10-fold following detention. All children reported experiences of traumatic events occurring during detention. These findings suggest the deterioration of mental health in detention associated with the detention process and specific experiences occurring in detention.

 Deans et al.16 found that over a 12-month period, there were 770 Emergency Department attendances at the Royal Darwin Hospital (RDH) by 518 individual detainees. Of this sample, 112 attendees were under 18 years of age. The most common reason for attendance was a psychiatric problem; psychiatric problems accounted for 24.3% of primary diagnoses, of which 138 were self-harm (15 of these attendances were by children, who were aged 9 to 17 years). Psychiatric presentations accounted for 13.7% (20 individual cases) of the child-aged sample.

 Lorek et al.15 found that 100% of children detained within a British Immigration Detention Centre reported symptoms of depression and anxiety. Sleep problems, somatic complaints, poor appetite, emotional symptoms, and behavioural difficulties were common. All parents reported symptoms of global distress. Based on paediatric assessment 8 of the 20 (40%) children had lost weight during their period of detainment. Nutritional, developmental, educational and child protection concerns were all raised.

**Discussion**

 Only a handful of relatively small studies have empirically investigated the psychological impact of immigration detention on children. Despite lack of substantial evidence to indicate the safety of this practice for the long-term well-being of children and families, the practice continues. The results of this systematic review indicate that available evidence points to high rates of psychological distress and diagnosable disorders amongst asylum-seeking youth in immigration detention centres. Rates are substantially higher than population averages (e.g. see DSM-IV17), and represent a major concern. Furthermore, the finding that all children had at least 1 parent with a mental health problem14 is of concern. Parenting ability and the parent-child relationship play a crucial role in child development and well-being18, and both of these can be disrupted when a parent has significant psychological difficulties19. This may be an important contributing factor to the emergence and maintenance of child developmental and psychological difficulties when in immigration detention.

 There are several methodological difficulties that must be noted. Studies have for the most part only conducted assessment at one point in time, preventing strong conclusions to be made about the individual impact of ongoing detention on psychological well-being. Mares and Jureidini14 qualitatively report that status deteriorated with increased time in detention, and Steel and colleagues13 report that retrospective assessments of pre-existing disorders indicate a significant increase in prevalence following detention, however prospective studies utilizing longitudinal methodology would be required to confirm this.

 Furthermore, the heterogeneity of samples, and the likely range and complexity of difficulties encountered by asylum seekers before and during detention make it difficult to isolate independent effects. Small sample sizes, as well as assessment of only those individuals presenting to health-care facilities, may limit generalizability of results to the population as a whole.

**Conclusion**

 Despite limitations, studies are consistent in findings of poor mental health among detained children and adolescent asylum seekers. Additionally, some evidence points to the deleterious effects of detention over time on young people. This is not surprising given the reports of a harsh environment, loss and/or incapacity of carers, exposure to traumatic events, exposure to parent’s distress and/or mental illness, and the absence of appropriate resources to support normal development through play and education (e.g. previous Human Rights and Equal Opportunity Commission Report 200411). In order to ensure that Australia fulfils it’s international obligation to avoid causing additional harm to those seeking asylum, more research is urgently needed into the long-term impact of detention on children and families, and if this practice is to be continued, appropriate interventions to reduce harm are required.

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