



## The mental and physical health difficulties of children held within a British immigration detention center: A pilot study

Ann Lorek<sup>a,\*</sup>, Kimberly Ehntholt<sup>c</sup>, Anne Nesbitt<sup>d</sup>, Emmanuel Wey<sup>b</sup>, Chipo Githinji<sup>b</sup>, Eve Rossor<sup>b</sup>, Rush Wickramasinghe<sup>b</sup>

<sup>a</sup> Mary Sheridan Centre for Child Health, Lambeth Community Health, SE11 4TH, UK

<sup>b</sup> Mary Sheridan Centre for Child Health, Lambeth Primary Care Trust, London, UK

<sup>c</sup> Traumatic Stress Clinic, Camden and Islington NHS Foundation Trust, London, UK

<sup>d</sup> City and Hackney Primary Care Trust, London, UK

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### ABSTRACT

**Objective:** The present study aimed to assess the mental and physical health of children held within a British immigration detention center.

**Method:** A total of 24 detained children (aged 3 months to 17 years) were assessed with their parents or carer after being referred by a registered legal charity. Thirteen were seen by a pediatrician alone, 4 by a psychologist alone, and 7 by both professions using semi-structured clinical interviews. The psychologist also used standardized self-report questionnaires to measure psychopathology.

**Results:** During the psychological assessment of 11 children, 8 met criteria for psychiatric “caseness” on the Strengths and Difficulties Questionnaire. All 11 reported symptoms of depression and anxiety. Sleep problems, somatic complaints, poor appetite, emotional symptoms, and behavioral difficulties were common. Symptoms of global distress were also reported by all 9 parents. According to pediatric assessment 8 out of 20 children had lost weight. Six had missed health appointments and 2 were taken to hospital. Nutritional, developmental, educational, and child protection concerns were raised.

**Conclusions:** Detained children were found to be experiencing mental and physical health difficulties of recent onset, which appeared to be related to the detention experience. These findings support previous Australian studies demonstrating that detention is not in the best interest of the child. It suggests that current UK policies regarding the detention of children for purposes of immigration control should be re-examined. Further research in the area is required.

**Practice implications:** Although high levels of mental and physical health problems, as well as child protection concerns were detected, detained families had very limited access to appropriate assessment, support or treatment. The traumatic experience of detention itself also has implications for the sizeable proportion of psychologically distressed children who are eventually released from detention and expected to successfully reintegrate into British society; while those children who are deported are returned with increased vulnerability to future stressors.

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\* Corresponding author.

## Introduction

Current British law allows for families with children subject to immigration control to be detained for indefinite periods of time. Detention can take place while the family's claim for asylum or other legal right to remain in the UK is determined, and if the claim is refused, until their removal from the UK (HMSO, 1999). Prior to October 2001, government policy was that children under 18 who were in the UK with their families should only be detained "as close to removal as possible so as to ensure that families are not normally detained for more than a few days" (Home Office, 1998, Chapter 12.5). In October 2001 the British government announced that it was changing its policy for families subject to immigration control to allow for their detention without time limit. This was despite other policy which has continued to state that detention must be "used sparingly, and for the shortest period necessary" (Home Office, 2008, Chapter 55.1.3).

The British government's use of detention for families with children has been condemned by numerous organizations for breaking international standards relating to the treatment of children as set by the 1989 United Nations Convention on the Rights of the Child (United Nations, 1989) and the 1999 United Nations High Commissioner for Refugees (UNHCR) Revised Guidelines Relating to the Detention of Asylum Seekers (UNHCR, 1999). The first states that the best interest of the child "shall be a primary consideration" in all decision-making (Article 3) and the second states that asylum seeking children should not be detained. However, the British government had entered a reservation to the UN Convention on the Rights of the Child which effectively excluded children subject to immigration control from the protection of the Convention. Safeguarding duties were further limited by the British government within its own legislation. Although section 11 of the *Children Act (2004)* places a duty on key agencies in Britain to safeguard and promote the welfare of children, the Act explicitly leaves out the immigration agency in its list of key agencies.

Serious concerns about the well-being of children held in British immigration detention facilities have been expressed by the United Nations Committee on the Rights of the Child (UNCRC) (UNCRC, 2002), the European Commissioner for Human Rights (Gil-Robles, 2005), charities (Burnham & Cutler, 2007; Cole, 2003; Crawley & Lester, 2005; Cutler, 2005), medical practitioners (Fazel & Silove, 2006; Fazel & Stein, 2004), Her Majesty's Chief Inspector of Prisons (HMIP, 2006b), the Children's Commissioner for England (Aynsley-Green, 2005), and the Parliamentary Joint Committee on Human Rights (Joint Committee on Human Rights, 2007). Her Majesty's Chief Inspector of Prisons, Anne Owers, has repeatedly recommended that children should not be detained. Her report published in July 2006 following an inspection of Yarl's Wood detention center, found that there was no evidence that children's welfare was taken into account when making decisions about initial and continued detention. The report recommended that the detention of children should be exceptional and for no more than a few days. It also advised that initial authorization procedures should be strictly followed with an immediate independent welfare and needs assessment carried out in order to set out a care plan and inform decisions on whether continued detention is appropriate. The report concluded that to address the matters of concern raised would "... require a complete overhaul of the detention of children, informed by a proper understanding of the vulnerability of children and the safeguards required in domestic and international law" (HMIP, 2006b, p. 5). Following her more recent 2008 visit to Yarl's Wood, Ann Owers reported that "the plight of detained children remained of great concern" (HMIP, 2008, p. 5).

An aspect of the detention experience highlighted as particularly traumatic for families is the practice and methods used in the sudden removal of children and parents from their homes without prior notice in order to transport them to detention centers. On occasions children have reportedly been removed while on their way to school (Aynsley-Green, 2005) or more commonly during "dawn raids" when families are suddenly awoken in the early hours of the morning by uniformed enforcement officers and pressured to leave the house at once with little time to pack any belongings or say goodbye to friends. Such incidents sometimes involve the use of excessive force (Cole, 2003), for instance in one case an adolescent was reportedly handcuffed (HMIP, 2006b). Families are frequently transferred over long distances, for example they may be taken from as far as Scotland to Yarl's Wood detention center, which is located in Bedfordshire, southern England. One-third of families were reportedly moved between detention centers located in different parts of the UK, rather than remaining in one place throughout their stay (Crawley & Lester, 2005). There are reports of children being separated from their parents (Cole, 2003). Examples include one father remaining in detention while his family members were released, and another deported leaving his wife and child in the UK. Also parents have sometimes been placed in separate centers. In at least one case the separation of parents from their children resulted in the child being placed in foster care (Burnham & Cutler, 2007).

The physical appearance of detention centers such as Yarl's Wood can also be intimidating for children as the buildings are surrounded by barbed wire and have uniformed staff. It has been noted that on arrival at the center, children need to pass through approximately 8–10 locked doors. The children are photographed and finger prints can be taken (HMSO, 1999). According to one report, to reach the family wing from reception a child must pass through a number of locked doors, be subjected to a search then pass through a barred "cell" door (Aynsley-Green, 2005). All detainees at Yarl's Wood, including children are required to carry identity cards with them at all times.

Facilities at Yarl's Wood include a classroom, nursery, and outdoor play area with staff to provide education and activities for the children. There is a family room and a communal eating area with centralized catering, which only provides food at set mealtimes. There is a 24-hour health service including sessional GP input provided by a private contractor, and previously one, now two, social workers employed by Bedfordshire Social Services to conduct independent welfare assessments. Despite on site provision, concerns have been raised about the failure to assess or consider children's welfare in decision-making, as well as a failure to adequately address child protection issues (Joint Chief Inspectors, 2005). Worries have been raised about the length of detention (Aynsley-Green, 2005; Cole, 2003; Joint Chief Inspectors, 2005) and the lack of access to good quality

legal advice (Joint Committee on Human Rights, 2007). Lack of provision for children with special needs has been noted (HMIP, 2008). There are reports of gaps in support for breast feeding mothers and concerns about inadequate nutritional provision (Aynsley-Green, 2005; Cole, 2003; Crawley & Lester, 2005; Mcleish, Cutler, & Stancer, 2002). Following an inquiry into the quality of health care at Yarl's Wood, it was reported by Her Majesty's Chief Inspector of Prisons that "underpinning systems were inadequate and the healthcare service was not geared to meet the needs of those with serious health problems or the significant number of detainees held for longer periods for whom prolonged and uncertain detention was itself likely to be detrimental to their well-being" (HMIP, 2006a, p. 5).

It is important to acknowledge that the group of children liable for detention are already a particularly vulnerable group as studies have found that refugee, asylum seeking, and immigrant children (although a heterogeneous group) are generally at higher risk of mental health and physical health problems than indigenous children living in the UK community (Fazel & Stein, 2003; Hodes, 2000; Levenson & Sharma, 1999). Multiple traumas and stressors are known to have a detrimental impact on children's mental health (Heptinstall, Sethna, & Taylor, 2004). This suggests that the emotional well-being and health of many detained children is extremely vulnerable and likely to deteriorate further if exposed to additional stressors or traumatic events. The risk of exposure to additional stressors and trauma is high within immigration detention centers, as riots, violence, hunger strikes, and incidents of deliberate self-harm, including deaths due to suicide, have been reported. One such incident occurred in 2005 within the family unit at Yarl's Wood immigration detention center with the death of an Angolan man who committed suicide on his first night in detention, while detained with his 13-year-old son (Herbert, 2005).

Despite the aforementioned expressions of collective concern, the British government has increased its use of immigration detention centers for children and families since 2001. Four British detention centers have now been purpose-built or adapted to hold families on a longer term basis. Currently Yarl's Wood is the main center used for detaining families, following the addition of 260 family beds in 2005. Its current capacity allows it to hold 405 individuals, which consists of both families and single females, with further expansion planned. In 2005 according to official government figures, 1860 children were held in UK immigration detention centers with 320 of these children being detained for more than 14 days (Home Office, 2006). More recent data showing the number of children detained each year broken down into the length of their stay in detention and the outcome, that is whether they are deported or released back into the community, is not readily available as no official government body is currently responsible for the systematic collection of these statistics. However, in the nine months up to 30 September 2006, 59% of individuals (age not specified) were removed from the UK at the conclusion of a detention episode (Home Office, 2007). In other words although there is insufficient data to look at trends, a significant number of children appear to be staying more than a week in detention and a significant proportion are being released back into the community.

While the UK government's practice of detaining children has increased since 2001, in contrast the Australian government has recently reduced its use of immigration detention for families in response to a number of human rights and administrative enquiries, sustained public protest, and medical research demonstrating that detention was damaging to the mental health of children and their caregivers. Previous studies completed in Australia (Steel et al., 2006; Sultan & O'Sullivan, 2001), the United States (Keller et al., 2003), and the United Kingdom (Bracken & Gorst-Unsworth, 1991; Robbins et al., 2005) have shown that confinement within immigration detention centers has a severe negative impact on the mental health of adults. To date, only three studies, all conducted in Australia, have focused on the well-being of children held in immigration detention centers. One of these was a small observation-based study which highlighted the negative impact of parental distress on care-giving (Mares, Newman, Dudley, & Gale, 2002). A second study (Mares & Jureidini, 2004) based on a series of families who had been in detention for over a year, found that all children above the age of six fulfilled criteria for both Post Traumatic Stress Disorder (PTSD) and major depression with suicidal ideation. Most of the children had attempted self-harm. Anxiety and somatic symptoms were common. The majority of preschool age children were identified with developmental delay, emotional problems, disturbed sleep and feeding routines, as well as delays in language and social development. Similarly, high levels of psychopathology were reported in a separate study of families detained for more than two years, with the experience of detention itself found to be detrimental (Steel et al., 2004).

It was unclear whether similar levels of morbidity existed for children held for shorter periods of time in British immigration detention centers. To date, there have not been any studies using clinical assessments to investigate the well-being of children held in UK immigration detention centers. Therefore, a team of pediatricians and a clinical psychologist set out to assess the mental and physical health of a small sample of children held within a British detention center. The clinical assessments involved semi-structured interviews, physical examinations, behavioral observations, and the completion of standardized self-report measures in order to establish whether the detained children suffered from difficulties similar to those previously found in children detained within Australian immigration detention centers.

## Method

### *Sampling process*

Families at Yarl's Wood immigration detention center who responded to a registered charity's (Bail for Immigration Detainees [BID]) advertisement for free legal assistance in challenging their detention were offered a clinical assessment by a pediatrician and/or clinical psychologist independent of the detention center. It was not always possible to offer children

**Table 1**  
Participant demographics.

Age group	0–12 months	1–4 years	5–10 years	11–18 years
Number	3	8	11	2
M:F	3:0	4:4	5:6	0:2
Ethnic origin	1 Nigeria	2 Central African Republic	2 Congo-Brazzaville	1 Jamaica
	2 Uganda	1 Jamaica 3 Nigeria 2 Uganda	2 DRC <sup>a</sup> 1 Ghana 1 Jamaica 2 Nigeria 2 Pakistan 1 Uganda	1 Pakistan
Number with single carer	3	8	9	1
Duration in UK prior to current detention (months) <sup>b</sup>	4 (0–4)	24 (14–43)	48 (18–108)	58 (44–72)
Duration of detention prior to assessment (days) <sup>b</sup>	43 (15–51)	50 (18–155)	32 (11–155)	57 (43–115)
Outcome after this episode of detention	3 released	4 released 4 deported	9 released 2 deported	1 released 1 deported
Number assessed by pediatrician	3	7	8	2
Number assessed by psychologist	0	2	8	1

<sup>a</sup> Democratic Republic of Congo.

<sup>b</sup> Expressed as median (range).

both pediatric and psychology assessments due to practical constraints. Children of all ages were seen by the pediatricians while the psychologist only assessed children aged 3 years and above.

A total of 33 families contacted BID during the time period of the study. None were prioritized on the basis of known medical needs. Of the 17 families not seen for a medical assessment, 13 were released or removed before a medical visit could be arranged and 4 families were not seen for reasons related to the legal process. It is difficult to provide any meaningful statistics regarding the total population of children and families who were held at Yarl's Wood during the period of the study (February–August 2006), as such figures are not routinely collected by any official government body or released to the public in any systematic way. In addition, the number of children detained within the family living quarters was extremely variable during the course of the study due to an outbreak of chicken pox and later a suspected measles case, which led to fewer children being admitted to the center.

### Participants

Twenty-four children were assessed from 16 different families. Of these family units, 6 had 2 children interviewed and 1 had 3 children interviewed during the assessment sessions. Children were aged 3 months to 17 (median 4.75) years. The total sample of children (12 boys and 12 girls) had been in detention 11–155 (median 43) days. The 14 children who were aged over 5 years had lived and been educated in England for 1.5–9 (median 4) years, including a 9-year-old who had been born in Britain. A total of 18 parents were interviewed. Most children (18 out of 24) were looked after by single mothers and two by a single male carer. Two families had both parents residing in detention. Family composition ranged from 2 to 5 individuals. Participants were fluent in English except for 1 family, who required a French interpreter. See Table 1 for further demographic details organized by the participants' age range.

### Overview of the procedure

Informed consent for the assessment and publication of findings was obtained from parents and where appropriate from the young person. Clinical information was collected from interviews lasting up to two hours with detained children in the presence of at least one parent. Basic medical and background information was also collected from the health center's medical records. A Welfare Needs Assessment had been completed and a copy was available within the medical records for one of the preschool children participating in the study. However, copies of this assessment were not filed within the medical records of any of the other children.

The assessment sessions took place in the detention facility's health center. A total of 24 children were seen, 13 by a pediatrician alone, 4 by a psychologist alone, and 7 by both professions. After completing the interviews, clinicians summarized their assessment findings within independent medical reports for BID. All concerns were also communicated both verbally and in writing to detention center staff.

Parent(s) or carers were always present in the room during assessments and were never interviewed separately from the children. If siblings were present then the clinician(s) assessed one sibling at a time and interviewed the parent(s) about each child separately. Three families had both parents present and on these occasions both parents were interviewed. The psychologist and pediatricians had all been trained in carrying out cross-cultural assessments and worked regularly with asylum seeking children and families. The assessment tools employed were in regular use at routine asylum seeking child

health assessment clinics. In an attempt to be cross-culturally sensitive, one of the main self-report measures used by the psychologist (the Strengths and Difficulties Questionnaire) was available in multiple languages so that the parents could complete this measure in their first language, which was hoped to improve comprehension and make the questionnaires less time-consuming to complete. Two parents chose to complete the French version, another couple chose to complete the Urdu version, and the rest of the parents opted to complete the English version of this questionnaire. In addition, a French interpreter was provided for one family at their pediatric assessment.

Approximately 10 weeks after the end of this study, BID provided the independent clinicians with data regarding whether the participating children had been deported or released back into the British community following their detention (see Table 1 for details).

### *Content of psychological assessments*

A total of 11 children (aged 3–11 years) were assessed by the clinical psychologist using clinical diagnostic interviews, observations, and self-report questionnaires. This sample consisted of 3 siblings from 1 family, 2 siblings from another family, and 2 cousins from the same family unit. The other 4 children came from separate family units and did not have any siblings participating in the study.

For the 5 younger children (aged 3–6 years), the psychologist relied more heavily on information provided by the parent, as well as on observations of the child's behavior during the assessment session. For the 6 older children (aged 7–11 years), more of the assessment relied on information obtained directly from the child. Areas covered within the clinical interviews were included on a checklist, which was completed at every interview. The assessment interview collected basic demographic facts followed by information about the child's personal history (including health and education), reasons for the family leaving their country of origin, nature of past traumatic experiences, as well as whether the child had any previous contact with mental health professionals. The interview then focused on whether the child was experiencing any symptoms of psychological distress, including depression, anxiety, PTSD, sleep problems, such as the emergence of nightmares, trouble falling asleep, or refusal to sleep except in bed with a parent, nocturnal bedwetting, encopresis, changes in appetite, somatic symptoms, such as headache and stomach pain, loss of previously acquired cognitive skills, regressive behavior, peer relationship problems, and conduct or behavioral problems.

*Self-report questionnaires completed by older children.* The six older children were also asked to complete a brief self-report measure of anxiety (the Spence Children's Anxiety Scale; SCAS; Spence, 1997) and depression (the Birlleson Depression Self-Rating Scale; DSRS; Birlleson, 1981). The SCAS is widely used in the UK to assess children's anxiety and is based on diagnostic criteria for anxiety disorders. It consists of 38 anxiety items and provides an overall measure of anxiety together with scores on six subscales including panic and agoraphobia, separation anxiety, physical injury fears, social phobia, obsessive compulsive, and generalized anxiety disorder/overanxious disorder. The DSRS is a self-report questionnaire consisting of 18 items which provides a measure of depressive feelings. Most normal children will not score above 11, and a score of 17 or over is highly suggestive of clinical depression.

If any of these older children reported suffering from distressing memories of past traumatic experiences then they were also asked to complete a Post Traumatic Stress Disorder (PTSD) measure (the Revised Impact of Event Scale-13 item; R-IES-13; Smith, Perrin, Dyregrov, & Yule, 2003). The R-IES-13 is used to measure the extent of distressing intrusive thoughts and feelings about past traumatic events, the mental energy used in trying to avoid these feelings, as well as physiological arousal. The maximum score on this scale is 65. A combined score of 17 or above on the Intrusion and Avoidance subscales strongly suggests that the individual is likely to meet diagnostic criteria for PTSD.

*Self-report questionnaires completed by parents or carer during assessment.* A total of nine parents were seen by the psychologist. Five were single parents or carers and four were married couples caring for two different family units. Parents were asked to complete the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1994) based on their child's behavior since their arrival in the detention center. The SDQ is a brief behavioral screening questionnaire that asks about children's symptoms, as well as positive attributes. It consists of 25 items which generate five subscales—conduct problems, hyperactivity-inattention, emotional symptoms, peer problems, and prosocial behavior, as well as a separate impact score. All subscales except for prosocial behavior are added together to produce a total difficulties score. Psychiatric "caseness" was defined from the combination of raised symptoms ( $SDQ \geq 14$ ) and impact scores ( $\geq 2$ ) (Goodman, Ford, & Meltzer, 2002).

A brief clinical interview was also conducted with all 9 adults, who were the children's parent(s) or carer. These adults were asked to briefly describe their own difficulties and were asked to complete the Clinical Outcomes in Routine Evaluation (CORE; Barkham et al., 1998) measure, which is a 34 item psychological screening tool designed to be suitable for use across a wide variety of service types. It measures global distress in adults, including subjective well-being, commonly experienced problems or symptoms, and life/social functioning. It also assesses risk to self and others. The mean of all 34 items can be used as a global index of distress.

### *Content of pediatric assessments*

Pediatricians assessed a total of 20 children (aged 3 months–17 years), and used a structured proforma based on standard clinical practice. Children aged 0–4 years were screened according to health promotion guidance (Hall & Elliman, 2003) and had developmental screening based on the Nfer-Nelson Schedule of Growing Skills II, as well as a general pediatric physical

**Table 2**Parent-rated scores for the detained children ( $n = 11$ ) on the Strengths and Difficulties Questionnaire (SDQ).

SDQ subscale	Median SDQ score (range)	Number of children in		
		Normal range	Borderline range	Abnormal range
Total difficulties	17 (7–25)	3	2	6
Emotional symptoms	5 (3–10)	1	3	7
Conduct disorder	3 (0–5)	5	4	2
Hyperactivity	4 (1–8)	8	1	2
Peer problems	4 (1–8)	4	1	6
Prosocial behavior	7 (3–10)	9	0	2
Impact on child's life	2 (0–7)	1	0	10

Normative values for parent-rated SDQ described as mean (*SD*) based on UK children aged 5–15 (Meltzer, Gatward, Goodman, & Ford, 2000): total 8.4 (5.8), emotional symptoms 1.9 (2.0), conduct disorder 1.6 (1.7), hyperactivity 3.5 (2.6), peer problems 1.5 (1.7), prosocial behavior 8.6 (1.6), and impact on child's life 0.4 (1.1).

examination. Older children were asked about their school progress and had a clinical assessment of their verbal abilities and memory, as well as a screen of their nonverbal abilities using a locally devised tool in use with multiethnic populations for routine school age assessment; and one child with possible learning difficulties was assessed using Raven's Progressive Coloured Matrices for nonverbal reasoning, and digit span and Wepman word list for auditory processing. Additionally, clinical examinations were offered to all children and undertaken with their consent.

### Ethics

The study was reviewed by the Chair of the South London and Maudsley, and Institute of Psychiatry Research Ethics Committee. The Chair then independently decided to pass it on to COREC for review. Following a review conducted by both bodies, the Chair communicated their final decision to the authors by email, stating that the study was not within the remit of an NHS REC as it was not NHS research and that it appeared to fall within the remit of service evaluation as it was based on independent routine clinical assessments.

### Data analysis

The results regarding the health of detained children and their parents were obtained through qualitative analysis of the information collected by the 6 pediatricians and 1 clinical psychologist during assessment interviews. Standardized self-report measures were scored and compared with previously established means and cut-off scores. Descriptive data were used to summarize participants' self-reported levels of psychological distress, general health complaints, child protection, developmental, and educational concerns.

## Results

### Psychological assessment of mental health

*Child mental health based on clinical diagnostic interview findings.* Psychological assessment revealed that since being detained all eleven of the children had begun to display symptoms of depression and anxiety. Ten out of the 11 children had begun to experience sleep problems, including nightmares and difficulty falling or remaining asleep. All 11 children had reportedly developed problems eating either due to the fact that they did not like the food provided or because of loss of appetite or abdominal pains. Ten out of 11 children had begun to complain of somatic complaints, which consisted mainly of headaches and abdominal pains. All 11 children presented as being disorientated, confused and frightened by the detention setting. Many asked the psychologist why they were in "prison" and when they would be allowed to go "home" again. None of the 11 children assessed had previously required support from a mental health professional.

*Child mental health based on parent-completed questionnaires.* According to parental ratings on the SDQ as shown in Table 2, since being detained the majority of the children assessed were experiencing high levels of emotional and behavioral difficulties. Emotional symptoms were most frequently reported in this sample as they were observed in 10 out of the 11 children. Seven children were rated as having problems in their peer relationships. Parents reported the emergence of conduct problems in 6 children who had previously been well behaved at home and in school. Another 3 children were reported as displaying hyperactive behavior. These current emotional and behavioral difficulties were reportedly having a severe negative impact on their child's current life (with 10 out of 11 scoring in the "abnormal" range). Overall, 8 out of 11 of the children (73%) were categorized as psychiatric cases, with approximately one-third in the "borderline" category and two-thirds in the "abnormal" category on the total difficulties score.

*Older children's mental health based on self-report questionnaires.* The 6 older children (aged 7–11 years) completed the DSRS and the SCAS. On the depression measure (DSRS), none of the children scored in the normal range. Five children were above the cut-off indicating a likely diagnosis of clinical depression and 1 child's score indicated the presence of low

mood. On the anxiety measure (SCAS), 4 children scored above the cut-off indicating that they were experiencing clinically significant levels of anxiety, while 2 children scored in the normal range. Of those scoring in the clinical range all 4 were above the cut-off on the subscale for separation anxiety, 3 for physical injury fears, 3 for generalized anxiety, 2 for panic, and 1 for obsessive compulsive symptoms. One child also reported experiencing the re-emergence of PTSD symptoms related to previous war experiences and was asked to complete the R-IES-13. This child's score was slightly below the cut-off, indicating that although she may not have met diagnostic criteria for PTSD, she was still suffering from significant PTSD symptoms.

*Parental mental health based on clinical interview and self-report questionnaires.* A total of 9 adults (3 men and 6 women) underwent a brief clinical interview with the psychologist. Five adults were single parents and 4 were married couples from 2 different family units. All 9 adults interviewed by the psychologist reported symptoms of anxiety and depression. All 9 reported that they thought it would be better if they were dead. The majority (6 out of the 9 adults) had contemplated suicide. Two mothers were actively suicidal and on suicide watch, with 1 requiring subsequent hospitalization following a serious suicide attempt.

Although not asked directly, 5 adults disclosed information about the nature of their past traumatic experiences with 2 fathers and 1 mother reporting that they were torture survivors, as well as 2 mothers stating that they had been victims of rape in their countries of origin. These 5 adults reported experiencing PTSD symptoms in relation to their past traumatic events. Three out of the 9 adults had previously been receiving psychiatric medication and counselling, which they reported had stopped abruptly upon their detention. Following the assessment, the psychologist recommended that 5 out of the 9 adults were assessed by a psychiatrist as a matter of urgency due to the severity of their mental health difficulties and level of risk.

Scores on the CORE self-report measure were also consistent with high levels of emotional distress. All 9 of the parents scored above clinical cut-off on the measure of global psychological distress (median 2.4, range 1.5–3.1); the mean and (*SD*) for a nonclinical sample is 0.76 (0.59). Seven of the parents also scored above cut-off on the Risk subscale (median 0.8, range 0.2–2.7); the mean and (*SD*) for a nonclinical sample is 0.20 (0.45). CORE normative data for Global Distress uses a cut-off of 1.19 for men and 1.29 for women, with a cut-off for Risk of 0.43 for men and 0.31 for women (CORE System Group, 1998).

Children and parents seen by the pediatricians reported symptoms, which were also consistent with the psychologist's findings.

#### *Pediatric assessment of physical health*

The main findings based on pediatric assessment were concerns related to poor nutrition within the detention center, high levels of health complaints of recent onset, chronic medical problems, and missed follow-up health appointments including those for vaccinations.

*Nutrition and Growth.* Most parents seen by the pediatricians raised concerns about nutrition. Of the breast feeding mothers, 2 had breast milk drying up in detention, 1 after forced separation from her 20-month-old child for 3 weeks and the other had felt hungry and had started to bottle feed her 3-month-old because she was unable to get food for herself after 5 p.m. The other mother continuing to breast feed had not been given Vitamin D. She was anxious that her breast milk was drying up for her 5-month-old baby because of stress and back pain, and had just started bottle feeds. Spontaneous concern was raised by 2 mothers about the cleanliness of the sterilizing equipment and lack of equipment to clean feeding bottles. For example, one mother was reportedly told to wash the bottles out with her own shampoo before sterilizing them.

All 7 parents of the 1–4 year olds reported finding restricted meal times stressful. Three children had regressed and refused to feed themselves or would only take milk. One mother reported that she had only been given a calorie supplement for a toddler who had regressed to total milk feeds. Some parents said that they could not get fresh milk for their children or were only able to give extra milk to children younger than 3 years of age. One child had a history of food allergy but the child's mother was unable to control the food provided in detention. Most parents of the older children reported that children had stopped eating nutritionally balanced meals, with some only eating chips or fruit. Many children spontaneously said that they did not like the food and preferred the food at home. One mother noted that some kitchen staff did not allow second helpings for children. Meal times were time limited and families could not take food back to their rooms.

Growth was assessed by comparing weight at the pediatric assessment with the admission weight of the child. There was incomplete data as not all children or babies were weighed on both occasions. The three infants in the study had all been weighed and were growing adequately. Of the 14 children with weights to compare, 8 had lost weight since admission and these had an average fall in standard deviation *z* score of 0.59. However, overall there was no significant difference in the weights or *z* score between arrival and pediatric assessment, although the distribution was unusually wide with significant weight lost by a 2-year-old and a 9-year-old, both of whom had apparently lost 10% of their body weight, while other children were gaining more weight than usual and had reportedly been eating a lot of snacks from a vending machine or were not as active as previously.

*Active health concerns.* See Table 3 for a summary of health problems in all children. Two young children required hospital care including a 2-year-old admitted with pneumonia and a 5-month-old with vomiting, loose stool, and irritability, whose mother's breast milk was decreasing in detention. Of the 20 children seen by a pediatrician, several had missed second tier medical appointments including dental care, hearing assessment, follow-up for spina bifida, surgical opinion for a lip lesion, follow-up of antenatal renal tract dilatation, HIV and syphilis test follow-up, and Hepatitis B testing of protection or infection after prior immunization. Six were recommended for additional medical management, including for a chronic

**Table 3**  
Health problems reported by detained children.

Age group	0–12 months	1–4 years	5–18 years
Number assessed by pediatrician	3	7	10
Number with new or increased symptoms since detention	2	7	9
Physical problems	1 Inguinal hernia 1 Eczema 1 Cough 1 Gastroesophageal reflux 1 Loose stool 1 Nappy rash 1 Fever	2 Eczema flare (1 excoriated) 6 Cough 3 Abdominal pain 3 Vomiting 2 Constipation 1 Pneumonia 2 Fever	1 Eczema 2 Cough 6 Abdominal pains 1 Vomiting 3 Constipation 3 Headaches 1 Ear infection with bloody discharge 1 Nosebleed 2 Fever
Hospital care	1 Ambulatory care	1 Admitted	0

cough and follow-up of fever and loose stool. One had a heart murmur and another was developing sleep apnea. One child needed review for clean intermittent catheterization and had been unable to contact her specialist nurse adviser from the detention center. In summary, most of the 20 children seen by a pediatrician complained of recent onset or exacerbation of physical symptoms. Two children required acute management at the local hospital, 1 for ambulatory care and the other was admitted with pneumonia.

*Preventative health and immunization.* Of the 0–4 year olds seen by a pediatrician, only 4 parents out of 7 had been able to keep or access their child's UK hand held health records at the center. One mother reported that her 17-month-old child had not been given a cot and had fallen out of bed. One mother reported that she had not been advised on cot death prevention despite the baby being born and brought up in custody. One baby had only been given part of their first primary immunization. In total, 3 children had missed planned immunizations because of being in detention. Only 4 children of the 20 children assessed by a pediatrician had evidence of age appropriate childhood immunization in line with Communicable Disease Control advice. One baby was felt to be at particular risk as this child had not been given BCG immunization. This child was also going to be returned un-weaned and bottle fed to Uganda if deported. Malaria prophylaxis, if offered and provided, was for 4 weeks protection only and did not include bed nets. One toddler had been given 4 weeks worth of antimalarials but had not been deported.

#### *Developmental concerns*

Of the 8 children aged 1–4 years old seen by pediatrician and/or psychologist, all mothers raised concerns about their children's development or behavior, including frequent crying or withdrawn behavior (8), food refusal (3), refusal to feed self (1), back in nappies day and night (3), and a 4-year-old regressed to bedwetting (1), plus day time soiling by a 3-year-old (1). These children also displayed other regressive behavior such as refusal to sleep apart from their parent(s), separation anxiety, and a return to thumb sucking. Four had regression of language. Three had mild language delay and another was selectively mute, 3 of these had a history of previously normal early language development, and the fourth child was found to have language delay and some developmental delay. Two children (aged 3 and 4) had reportedly lost previously acquired cognitive skills, such as being able to count and name the primary colors.

Of the older children assessed, 2 boys (aged 8 and 9) and 3 girls (aged 7, 9, and 11) disclosed bed wetting which had begun upon being detained. The 7-year-old girl was also wetting and soiling herself in the daytime. One older boy had Attention Deficit Disorder and borderline learning difficulties, with increased difficulties since detention.

#### *Educational concerns*

Spontaneous concerns were raised about the detention center's educational provision. Several mothers found it hard to settle their child in nursery because of separation anxiety. One mother said that she felt hygiene in the nursery was poor. Difficulty accessing regular crèche provision was an issue for one mother who was suicidal and finding her child's behavior difficult to manage. Families reported that the children were not allowed to take detention center toys or books to play with in their rooms. One child was distressed over being unable to take important exams and an older child was unable to carry out college work. Many of the older children complained that they missed having a "real school" and were frustrated that they did not feel they were learning anything. All of the older children said that they missed their friends and school and were distressed that they had not been given an opportunity to say goodbye.

#### *Child protection issues*

During assessment interviews with all 24 children, several issues related to child protection became apparent. For instance, one mother with suicidal ideation disclosed that she had hit her child. Two others spontaneously disclosed that

they were finding it hard to cope with their children's behavior. One mother reported that she had to take her sleeping pills at 6 p.m. every evening and so felt unable to look after her children. Several parents were on hunger strike. These adults admitted that they were finding it difficult to concentrate and perform daily tasks as a result. Two children had been placed in detention under the care of an adult with whom they had never previously lived.

Of the children seen by a pediatrician, at least 12 had been separated from a main caregiver. For instance, 3 children were separated from their mother for 24 hours during which time they stayed with their father at the detention center before their mother joined them. Two siblings from another family were separated from each other and their mother for unclear reasons, with the 2-year-old being taken from the mother and placed in foster care and her 5-year-old being put in a separate foster placement while the mother was detained. This mother reported that they were reunited in detention 2 weeks later. Another mother and her 20-month-old breast feeding child were separated for three weeks apparently because an existing outbreak of chicken pox at the detention center meant that children could not be admitted. Another mother reported that she had her child forcibly taken from her and was told that she could have her child back if she left the country.

One parent spontaneously complained that he had found his daughter in the center without any clothes on. His child explained that she had been encouraged to undress and play "sex games" instigated by another detained child. This father felt that there was inadequate supervision of the children within the center and after this incident he no longer allowed his children to play with the other children. Another mother spontaneously commented on the sexualized behavior of children within the center.

## Discussion

### *Clinical implications*

This study's findings indicate that the experience of detention, even for a relatively brief period of time, has a detrimental effect on the mental and physical health of children. According to the mental health assessments conducted, this sample of children appeared to be experiencing high levels of depression, anxiety, sleep problems, somatic complaints, emotional symptoms and behavioral difficulties since being detained. These findings are consistent with the type and severity of difficulties reported in previous Australian studies (Mares & Jureidini, 2004; Mares et al., 2002; Steel et al., 2004). However, this study differs from previous research as it was based on a sample of children who were held for a shorter period of time (less than a year) and within British rather than Australian detention facilities. The children in this sample had also lived within the UK community prior to their detention and had been relatively settled while those in Australia were detained immediately upon arrival.

It was not within the scope of the present study to compare the sample of detained children directly with a matched control group, however general comparisons may be made to previous research. According to one recent study, 27% of 101 asylum seeking and refugee children living in the UK community met criteria for psychiatric "caseness" according to teacher-rated SDQ scores (Fazel & Stein, 2003). In comparison, the present study's sample appears to be significantly more distressed as 73% (8 out of 11) fulfilled criteria for psychiatric "caseness".

As none of the detained children reported receiving prior support from mental health professionals, their SDQ scores could be understood to reflect a sudden deterioration in mental health due to the experience of detention rather than any pre-existing problems. The detained children's mental health is likely to have been negatively affected by a combination of factors including a recent deterioration in their parent's mental health and parenting ability, increased fear due to being suddenly placed in a facility resembling a prison, anxiety over the possible return to their country of origin where they may have previously experienced traumatic events, as well as the abrupt loss of home, school, friends, and all that was familiar to them.

The experience of detention also appears harmful to the mental health and parenting abilities of the children's caregivers. Although less rigorously assessed, the parents participating in this study also appeared to be a particularly vulnerable group as many had been receiving psychiatric treatment prior to detention and reported having experienced extremely traumatic events, including torture, imprisonment or rape, in their countries of origin. These adults were therefore at high risk of experiencing a severe deterioration in their already fragile mental health if confronted with additional stressful events, particularly if the events were to trigger memories of past traumatic experiences. Most parents explained that their experience of detention in the UK reminded them of past traumatic events which they had suffered in their home countries. They reported that the initial phases of the detention process were especially traumatic as they were often taken suddenly by uniformed men who entered their homes during early morning "dawn raids" and did not allow them adequate time to pack their children's belongings or say goodbye to anyone. Some parents also mentioned that the detention environment resembled a prison in many ways with its barbed wire fences, locked doors, frequent roll calls, use of identity cards and body searches. It therefore does not seem surprising that this group of detained adults reported high levels of global distress. As previous research has shown that poor parental mental health (Mghir, Freed, Raskin, & Katon, 1995), particularly maternal mental health (Ajdukovic & Ajdukovic, 1993; Smith, Perrin, Yule, & Rabe-Hesketh, 2001), and poor parenting ability (Rutter, 2002) are associated with increased psychological difficulties in children, these factors are also likely to have contributed to the emergence of mental health difficulties in the detained children.

Detained children had frequent and significant physical health problems. While many were common symptoms in childhood, it is of concern that most of the children were unwell in detention, that any pre-existing symptoms had worsened

since being taken into detention, and that two needed hospital care. It is of particular concern that a child with a severe but stable neurological problem requiring self catheterization found that her condition had worsened as she was unable to contact her specialist nurse while detained and so lost normal functioning in detention. While bed wetting can take place throughout childhood it is unusual for a previously consistently dry child to start to wet. Therefore the pattern observed in this sample of detained children was abnormal, particularly when seen in the older children who had been dry for many years. Thus the bed wetting is likely to be a reaction to severe stress.

These children may have multifactorial reasons for poor health or development and may have had difficulties accessing appropriate care within the community (Burnett & Peel, 2001; Davidson et al., 2004; Hayes et al., 1998; Levenson & Sharma, 1999). However, any child with pre-existing health or developmental concerns continues to require appropriate care, intervention, and support which this study's sample had not received in detention. It is unacceptable for children to miss immunizations (unless contraindicated) while under the care of the detention center's health care services, particularly as these children would be vulnerable to various diseases if deported to their home countries and within the detention setting. Indeed the children's carers were particularly aware of the risks of infectious disease if their child was left unprotected and had asked for immunizations to be given in detention. Any child with pre-existing developmental difficulty would benefit from early intervention and supportive parenting. This would be particularly important in the detention setting given the apparent regression in language of four of the children and regression in behavior of many. Most parent held medical records were not brought from home given the rush to collect personal belongings, and in at least two cases the parents' hand held records were taken from them in detention indicating poor continuity of care and lack of support for parental advocacy. Other findings in this study regarding health and nutrition concerns, as well as lack of provision for special needs are consistent with those found in a number of previous reports by charities (Cole, 2003; Crawley & Lester, 2005; Mcleish et al., 2002), the Children's Commissioner (Aynsley-Green, 2005), and the Chief Inspector of Prisons (HMIP, 2008).

#### *Service/policy implications*

Previous research has shown that asylum seeking children are vulnerable and at increased risk of mental health difficulties (Ehnholt & Yule, 2006; Lustig et al., 2004), as well as physical health problems (Davidson et al., 2004; Hayes et al., 1998). These children are therefore recognized as a high needs population who require ready access to appropriate medical assessments and treatment, including immunizations that would be life saving if they were to be deported. In view of the likely mental health needs of carers and constraints on parenting, detained children would benefit from a holistic, multiagency approach to assessments which should be carried out by independent specialist professionals, and should take into consideration the needs of the carer as well as the child so that the welfare of the child can be a priority and parents can be supported in parenting. This study found that opportunities for providing high quality health care were being missed. Within the detention center setting there was instead a noticeable gap in access to specialist holistic mental and physical health assessments, as well as treatment provision for children and parents. This gap has serious implications and needs to be addressed urgently in terms of practice and policy making.

This is the first study of its kind in the UK, therefore its preliminary findings have important implications for professional bodies, health authorities, government officials, and policy advisors. The high levels of mental and physical health difficulties detected support the view that detention, even for short periods of time, is detrimental and not appropriate for children. Within the detention setting, the impact of parental mental health difficulties on children's health, development, and safety did not appear to have been recognized or addressed. Opportunities for preventative health care were being missed and there was clear evidence of a lack of continuity of health care. A number of serious child protection concerns were raised. Social and educational needs were not being adequately met. It is also of concern that children were being sent back bottle fed and preweaning to countries where bottle feeding is more dangerous than breast feeding. It is also worrying that children were being sent back to countries with a high incidence of malaria without bed nets, when they will have either lost or have no natural immunity.

The traumatic nature of the detention experience itself is also likely to have long-term negative consequences which must not be overlooked. Not only are large numbers of detained children returned to their countries of origin with increased vulnerability and elevated levels of emotional distress but according to government statistics, approximately one-third of all detained children are eventually released back into the British community. Besides suffering from increased levels of psychological distress related to the experience of detention, these children often will have lost their previous accommodation while detained and need to be re-housed in different parts of the UK. This then leads to further losses and disruption to these children's education, social support networks, and health care. Such issues need to be urgently addressed and improvements made to current policies in order to protect the future well-being of such vulnerable children.

#### *Ethical/human rights implications*

The current UK practice of detaining children clearly carries both ethical and human rights implications. The British government's decision to place a reservation on Article 22 of the UN Convention on the Rights of the Child meant that the government failed to meet its international obligations to protect the rights of all children. Although in 2008 the UK government decided to remove this reservation, it is not yet clear what impact, if any, this will have on the government's ongoing practice of detaining children subject to immigration control. As of yet there have not been any noticeable improvements in

the way children subject to immigration control are being treated in the UK. Concerns recently expressed by Her Majesty's Chief Inspector of Prisons (HMIP, 2008), the UK Children's Commissioners (UK Children's Commissioners, 2008), and the UN Committee on the Rights of the Child (UNCRC, 2008) still have not been adequately addressed.

This study's findings demonstrate that the rights promised under the UN Convention on the Rights of the Child are not afforded to children in detention particularly in relation to best interest (Article 3), responsibilities and rights of parents (Article 5), separation from parents against their will (Article 9), the right of families to be together (Article 10), and detention as a measure of last resort (Article 37). In addition, the detention of children fails to meet the British government's own policy targets as set out in 2004, which aims to ensure that all children living in the UK have the right to be healthy, stay safe, enjoy, achieve, make a positive contribution, and access education so that they can achieve future economic well-being (Her Majesty's Government, 2003). We concur with the UK Children's Commissioners report to the UN Committee on the Rights of the Child which states that "The child's best interests are not a primary consideration in immigration decisions. Immigration control takes priority over human rights obligations to children seeking asylum and their families" (UK Children's Commissioners, 2008, p. 30).

### *Study limitations*

It is important to recognize that this was a pilot study based on a small sample of 24 children who were assessed at a single time point. Also, as these children were placed in detention without any warning and for indeterminate periods of time, it was difficult to conduct initial and follow-up assessments at set time points. A further weakness is that there may have been considerable selection bias in the way that participants were recruited as they were a group who had responded to an advert from a legal charity, whose main purpose was to support detainees pursuing bail. As the findings were based mainly on self-report, it could be argued that the families exaggerated their psychological or physical difficulties in the hope that it would lead to their release from detention. Many participants may have hoped that the outcome of their independent health assessments would help their legal case to stay in the country. For this reason some bias in symptom reporting is possible. However, this seems unlikely as symptoms of severe distress were also frequently observed during the assessment sessions, that is many participants cried or appeared visibly exhausted from lack of sleep and one woman wore bandages on her body from previous incidents of self-harm. This sample also consisted of families who were mainly fluent in English and had been in the country for several years prior to their detention. Therefore it might not be possible to generalize these findings to those newly arrived families, who are detained immediately upon their arrival in the UK. However, this study's sample is representative of the many children and families who are detained after living for lengthy periods within the British community, as the asylum process often continues for many years before families receive a final negative decision on their applications and are liable for deportation.

Conducting research with this population is particularly difficult for a number of reasons, beginning with the problem of gaining access to detained families and obtaining their consent to participate in assessments for research purposes. Also, the complex and often traumatic previous histories of these children make teasing out the cause of their current difficulties problematic. For instance, while some children are likely to have mental and physical health problems prior to detention, and while detention is likely to exacerbate previous difficulties, it is not always possible to demonstrate a clear deterioration as it may be impossible to assess any of the children prior to their detention in order to establish a reliable baseline. Complex assessments are also required in order to separate the impact of past trauma from responses to current incarceration. Further challenges arise out of the cross-cultural issues inherent in offering assessments to families originally from different countries and cultural backgrounds, who in our study often did not speak English as their first language. This process was made somewhat easier due to the fact that most of these families had lived in the UK for at least several years, had acculturated to the British way of life, and had become relatively familiar with the way in which health assessments were carried out. Many of the parents had been previously assessed and were in treatment with mental health professionals prior to being detained and thus were used to the type of questions frequently asked regarding psychological well-being.

A comprehensive prospective study which would address the limitations of the current study urgently needs to be conducted. Future studies should aim to replicate the present study with larger numbers of participants randomly chosen from the general population of detainees and with repeated assessments over time. Although extremely difficult to achieve due to practical constraints, an ideal study design would involve individually matching a sample of asylum-seeking children held in immigration detention based on age, gender, country of origin, nature of past experiences, and time living in the UK with a control group of asylum-seeking children at risk of imminent deportation but still living in the community. Such a study would allow researchers to investigate with greater certainty whether the experience of detention itself leads to a significant deterioration in the mental and physical health of children, as this current study would appear to suggest.

### *Conclusions*

This study clearly provides evidence that the British system of immigration detention, although often relatively brief, is nevertheless potentially harmful to the mental and physical well-being of children. These findings support those of previous reports that detention is not in the best interest of the child and should not be used for the purposes of immigration control. As there is currently no clear evidence to indicate that detention is necessary in order to prevent families from absconding, more

humane alternatives to current practice must be explored. In the meantime, further statutory safeguards and reconsideration of Britain's policy of detaining children are urgently required.

Clinicians have not just an ethical responsibility but also an important role to play in acting as advocates for vulnerable populations. This group of detained children are clearly vulnerable, marginalized, and at risk of mental and physical harm as a result of state sanctioned neglect (inadequate care and protection), and possibly abuse in the sense of exposure to violence within the detention facilities themselves. Health commissioners, professional bodies, and practitioners in the UK therefore have an ethical duty to respond to these findings by ensuring that a comprehensive prospective study into the mental and physical well-being of children in detention is conducted and to advocate for review of the current UK detention policy as a matter of urgency.

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