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The Mental Health of Children and Parents Detained on Christmas Island: Secondary Analysis of an Australian Human Rights Commission Data Set

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Abstract

This paper describes secondary analysis of previously unreported data collected during the 2014 Australian Human Rights Commission Inquiry into Children in Immigration Detention. The aim was to examine the mental health of asylum-seeking parents and children during prolonged immigration detention and to consider the human rights implications of the findings. The average period of detention was seven months. Data includes 166 Kessler 10 Scales (K10) and 70 Strengths and Difficulties Questionnaires (SDQ) for children aged 3-17 and parental concerns about 48 infants. Extremely high rates of mental disorder in adults and children resemble clinical populations. The K10 indicated severe co-morbid depression and anxiety in 83% of adults and 85.7% of teenagers. On the SDQ, 75.7% of children had a high probability of psychiatric disorder, with lower conduct and hyperactivity scores than clinic populations. Sixty-seven percent of parents had concerns about their infant's development. Correlations were not found between time detained or parent/child distress. Multiple human rights breaches are identified, including the right to health. This is further evidence of the profound negative consequences for adults and children of prolonged immigration detention. Methodological limitations demonstrate the practical and ethical obstacles to research with this population and the politicized implications of the findings.

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Introduction

In 2014, the Australian Human Rights Commission (AHRC) conducted an inquiry into immigration detention of children. This paper reports secondary analysis of data not analyzed or included in the inquiry report that was collected by the AHRC in March 2014 from children and families detained on Christmas Island (CI). Data included 166 Kessler 10 Scales (K10) for adults and adolescents, and 70 Strengths and Difficulties Questionnaires (SDQ) for children aged 3-17, plus responses from parents of 48 infants to questions about their wellbeing. The human rights implications are discussed.

Background

The UNHCR reports that 65.3 million people around the world are currently displaced, including 20 million already identified as refugees. More than half are children.[1] Australia is a signatory to the UN Refugee Convention (1951), and in December 1990 ratified the Convention on the Rights of the Child (CRC).[2] The CRC rights are largely enacted in policies for Australian children but not incorporated in law. Australia maintains a generous offshore refugee resettlement program, in stark contrast to the reception given to asylum seekers arriving by boat without documentation. Numbers are small in international terms: In 2013 and 2014, Australia granted positive refugee determinations for 4,949 people, which was 88% of those who had arrived by boat.[3]

Since 1992, Australia has had a policy of mandatory indefinite detention of all children and adults arriving by boat without valid documentation. This has been extended to include offshore processing and changes to the migration zone. In September 2012, the government reinstated third country processing and announced a regional settlement arrangement (RSA) under which people arriving by boat after July 19, 2013 would be transferred to Nauru or Manus Island in Papua New Guinea for processing, precluding resettlement in Australia. Between July 2013 and December 2014, while the RSA was negotiated, adults and children remained detained in Australian mainland centers and on CI, a remote island in the Indian Ocean, northwest of Australia.

Australia's policies and practices have been the subject of sustained criticism from local and international human rights and medical organizations, including the UNHCR.[4] For detained asylum seekers, the rights to work, education, human dignity, non-discrimination, equality, the prohibition against torture, privacy, and access to information, as well as the freedoms of association, assembly, and movement are all demonstrably compromised, with consequent impact on the right to health. There are identified breaches to the International Bill of Rights, the International Covenant on Civil and Political Rights (ICCPR), and the CRC, and evidence of demonstrable harm caused by indefinite detention and its consequences.[5] Recent concern has particularly focused on conditions for those held indefinitely under the RSA on Nauru and Manus Island.[6] In 2015, the UN Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment concluded in relation to the regional processing centers that "the Government of Australia...has violated the right of the asylum seekers, including children, to be free from torture or cruel, inhuman or degrading treatment, as provided by articles 1 and 16 of the CAT."[7] The AHRC has conducted two inquiries into immigration detention of children, the first in 2002 (reported in 2004), and the second in 2014. The 2004 report states that the failure "to protect and promote the mental health and development of children … not only constitutes a breach of a child's right to mental health, development and recovery, it also amounts to cruel, inhuman and degrading treatment."[8] The AHRC found Australia in breach of multiple articles of the CRC, in particular Article 3(1), which states, "the best interests of the child must be a primary consideration in all actions concerning children."[9] The 2014 report identified that "the laws, policies and practices of Labor and Coalition Governments are in serious breach of the rights guaranteed by the Convention on the Rights of the Child and the International Covenant on

Civil and Political Rights." The conclusion of this inquiry aligns with scientific studies: "Prolonged, mandatory detention of asylum seeker children causes them significant mental and physical illness and developmental delays, in breach of Australia's international obligations."[10]

The Australian government's responses to the two inquiries differed.[11] In 2004, evidence of the harms caused by immigration detention was considered new, and while the immigration minister disputed the findings, there was no sustained attack on the AHRC. Protective amendments to the Migration Act followed a change of government in 2007. The 2014 report was received with great hostility, including claims that the AHRC president had lost the government's confidence and should step aside.[12] There was a sustained political attack on the AHRC with little attempt to deny the evidence that Australia's policies cause significant harm. The Australian Border Force Act, enacted in 2015, potentially criminalized medical witnesses who spoke out about their experiences within immigration detention.[13]

Detained families and children receive health care through a government contractor, currently International Health and Medical Services (IHMS). Decisions about health needs and care provision are not transparent and there is no independent oversight or review body. Staff at IHMS and the Immigration and Border Protection system are subject to employment contracts and laws that prohibit disclosure of details surrounding detention conditions, which potentially puts them in conflict with professional standards and obligations.[14] Some doctors previously employed by IHMS have argued that health workers in immigration detention may be condoning torture.[15] In addition, given that detention itself is pathogenic, access to health care—no matter how adequate or independent—cannot sufficiently protect or treat detainees.

In mid-2014, IHMS began reporting Kessler Psychological Distress Scale (K10) mental health data from detained adults to the Australian government, and starting in mid-2015, they included Strengths and Difficulties Questionnaire (SDQ) data from children. This data was released under the Freedom of Information Act (FOI), and while it was not subject to scientific scrutiny, it clearly demonstrates clinical levels of mental health problems in detained adults and children, and shows deterioration over the period of detention. SDQ screening from 45 children shows that 82% were significantly symptomatic, scoring in the abnormal or borderline range.[16]

Scientific literature

Displaced adults and children face multiple, cumulative risks, including conflict-related exposure, trauma, and losses pre-migration, in transit, and post-arrival. Host countries support or undermine their wellbeing, with post-migration detention and insecure asylum status being particularly detrimental.[17] In 2002, this author, with other colleagues, first published descriptions of the impact of the harsh physical and psychological environment within Australian immigration detention on children and families.[18] Researchers subsequently carried out small quantitative studies demonstrating that the system was causing harm to children.[19] This added to existing research about detained adults.[20] Despite their methodological variety and limitations, international studies and review papers consistently show poor mental health among asylum seekers who have been detained, and there is evidence that even brief periods of detention—including in open centers—can impact children's functioning.[21] Rates of mental disorder are higher than in non-detained refugees with similar pre-migration risks, and length of detention is directly related to severity of symptoms.[22] Unaccompanied children, predominantly adolescents, have particular vulnerabilities due to their separation from family.[23] There is a small qualitative literature on the wellbeing of pregnant and postpartum asylum seekers, but barely any reports regarding detained infants and young children.[24] Infancy and early childhood is a period of profound dependency and rapid development, when cumulative adversity—including neglect, violence, and parental mental illness can have

long-term impacts across multiple developmental domains. Infants are over-represented in displaced populations, but a review by Fazel and colleagues identifies only 5 of 44 studies that include children under five.[25]

The study

Methods

The primary data was collected in March 2014 during the AHRC National Inquiry into Children in Immigration Detention. The author was Royal Australian and New Zealand College of Psychiatrists (RANZCP) consultant to the Inquiry and was involved in developing the methodology and collecting the data. Detailed observations made during AHRC visits to CI are reported elsewhere.[26] This study undertakes secondary analysis of data that was collected but not analyzed as part of the inquiry and was obtained under FOI in July 2015. It is therefore secondary and in the public domain. Redaction of gender and country of origin occurred before release under FOI. The project was submitted to the South Western Sydney Local Health District Human Research Ethics Committee (HREC/15/LPOOL/556), which was satisfied that the rights of participants had been protected.

Context

Christmas Island (CI) is a tiny island in the Indian Ocean covered in dense tropical forest. Small areas are cleared for phosphate mining, and there is a coastal settlement and diverse local population of about 2,000. Island life is dominated by the influx of staff and facilities associated with Australia's immigration and border protection services.

Families were held in indefinite detention on CI with the threat of transfer to Manus or Nauru or resettlement in third countries. Despite their designation as Alternative Places of Detention (APOD), the camps that housed families and unaccompanied minors resembled prisons. They were harsh and cramped, surrounded by high double fences—some of which were electrified—and guards were stationed at security gates. The ground was hard and stony, there was no grass, limited shade, and white phosphate dust covered everything. Families slept in small cabins with limited privacy, some shared bathrooms. There was little for anyone to do.

In this institutionalized setting, protective experiences for children were largely absent. Risks included exposure to parental mental illness, adult violence, and self-harm; family separations; and a developmentally impoverished environment. All adults and children were woken for head counts at 11 pm and 5 am, when they had to state their ID numbers. ID cards were required when lining up for meals or medical care. Children had few places to play safely and had received only a few weeks of schooling in the previous year.

The 2014 AHRC report identifies multiple breaches of the CRC in relation to the rights to development, health, education, and treatment with humanity and dignity.[27]

Ethical considerations

Research with detained populations is difficult and contentious, as it intersects medicine, politics, human rights, ethics, and law. In Australia, there are additional practical and political barriers.[28] These include extreme access limitations associated with the often very remote and penal nature of detention centers. Restrictions are justified on the basis of security, and prevent independent scrutiny and research on the impact of Australia's policies. If access was possible, obtaining informed consent is problematic, particularly with children, and given the extreme cultural and linguistic complexity of the population. Recent legislative changes, including the Australian Border Force Act (ABF) potentially criminalize individuals, including the author, who speak or write about the detention environment or contact with detained asylum seekers.[29]

Secondary analysis of an existing data set involves further consideration of existing data in order to answer the original research question using a different technique, or to present differing or additional interpretations. The approach has been used more with quantitative than qualitative data.[30] It raises ethical questions about consent

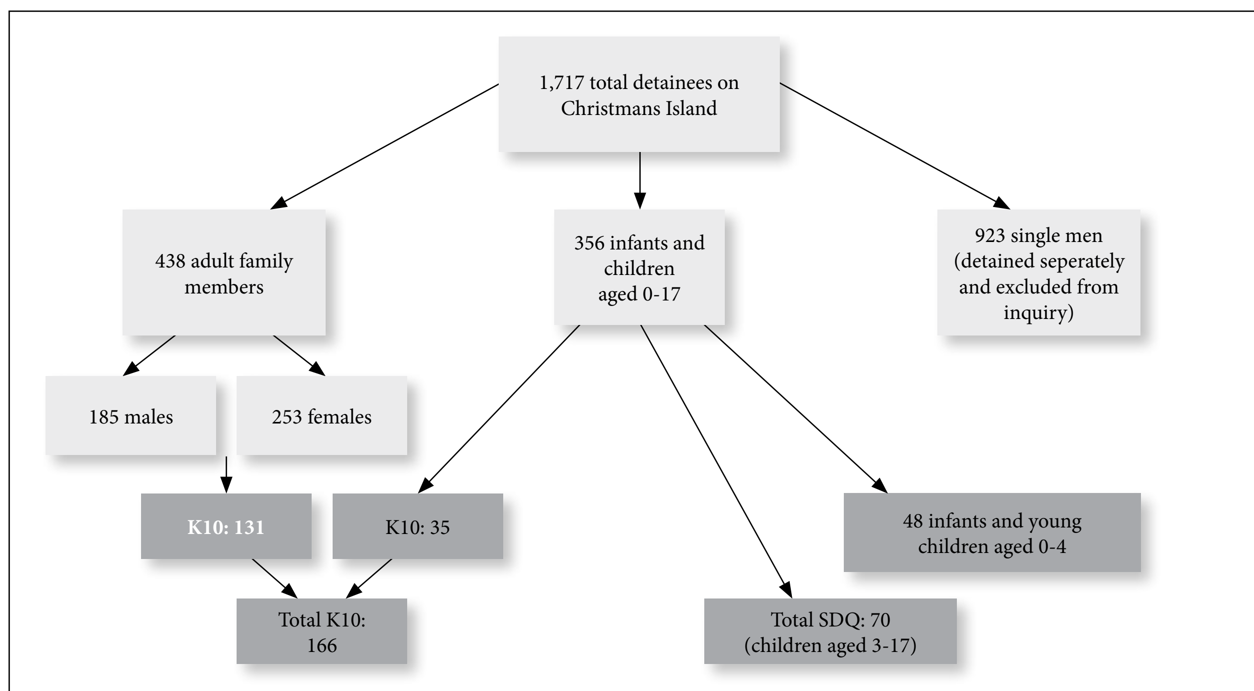
and protection of original participants.[31] Multiple steps were taken to protect participants during primary data collection and release under FOI. It was impracticable to obtain explicit consent for this study, which was not anticipated when the data was collected. It is also impossible to identify, locate, or recontact participants. Detention of children and families on CI ceased in December 2014, and all detainees have been transferred to Nauru or Manus, returned to their country of origin, or held temporarily in Australian centers or the community. This project is consistent with the aims of the primary data collection and adequately protects participants.

Primary data collection

In March 2014, children across Australia's immigration detention network had been detained for an average of eight months and were from 16 language groups, predominantly from Iran, Sri Lanka, Iraq, Afghanistan, Vietnam, Somalia, and a small number from Syria. The second largest group was Rohingya children, identified as stateless.[32] The AHRC inquiry obtained approval from the Department of Immigration and Border Protection (DIBP) to access detention centers in Australia, including CI. DIBP data shows that 1,717 detainees were held there before the AHRC visit in March 2014.[33] This included 923 single men separately detained and excluded from the inquiry. All family members and 41 unaccompanied minors (UAM, children under 18 years old without family) were invited to participate. There were 356 children aged 0-17 years held with 438 adults (185 men and 253 women). Twenty-five infants had been born into detention and 20 women were pregnant. No processing of asylum claims had occurred since July 2013.

Interviews were conducted in language groups using interpreters. The purpose of the AHRC inquiry was explained. Informal and semi-structured interviews and brief self-report questionnaires were completed. The inquiry methodology is outlined elsewhere.[34] Self-report measures included the K10 and SDQ. Only selected questions from these measures were included during visits to other detention centers and all data was collated for the report. Therefore, K10 and SDQ data from asylum seekers on CI has not been analyzed previously.

Figure 1: Population sample



Measures

The K10 is a self-report scale of psychological distress.[35] High distress scores indicate likelihood of a mental disorder. It has been validated in population-based and clinical populations and with a wide range of language and cultural groups, including refugee populations.[36] The SDQ is a brief behavioral screening questionnaire completed by the parent or carer, or self-reported for children aged 12-17. It is used in population and clinical studies to identify those at risk of mental illness. The 20 items are summed to create a "total difficulty" score ranging from 0-40 and 5-factor subscales (hyperactivity-inattention, emotional symptoms, peer problems, conduct problems, and prosocial behavior).[37] It has been used with migrant and refugee children, making it an appropriate measure in this population.[38]

Secondary analysis

The AHRC provided data from 365 people under FOI. This included 174 adults, 77 without children, and 97 adults in 69 family groups. The 191 children represent 48% of the 356 children then detained on CI. Time in detention, ages of children, exposure to violence, and parental concerns was provided. Gender, individual country of origin, and language group was redacted. Complete K10s were available and analyzed for 131 adults and 35 adolescents aged 12-17, 166 in total, and 70 SDQ for children aged 3-17. Parental concerns about 48 infants were collated.

Limitations

The data available for analysis has many limitations. It is not possible to determine whether this is a representative sample of the population detained on CI in March 2014; however, age and language group distribution of all children then detained in Australia was similar.[39] AHRC inquiry team members collected primary data in extremely noisy and distressing circumstances. Redaction of gender and country of origin information limits the richness of possible analysis. Levels of distress may have influenced participation. The data is incomplete in that there is only data (time in detention, SDQ and/or K10 data) for 131 adults and 105 children aged 3-17, and qualitative data on parental concerns about 48 infants. Some data was omitted or entered incorrectly during primary collection or FOI release. Five children had no age recorded, 15 are identified as UAM, yet 58 are not recorded as being part of a family and 77 of the 173 adults are not recorded as having children. This is likely to represent single women detained with the families, but may

TABLE 1: Population data

	Age	Number	K10	SDQ (ages 3-17)
Adults	18 and over	173	131	
Children	0-4	48 (25.1%)		
	5-11	104 (54.4%)		
	12-17	39 (20.4%)	35	
With parents	12-17	24/39		
Unaccompanied	12-17	15/39		
			Total K10 = 166	
Total children	Mean 7.64	191		Total SDQ =70
Family groups		69		
Time detained	Mean	Range	SD	
	209.5 days (7 months)	90-390 days	62.36 days	

The 129 children for whom data was available for secondary analysis included 48 infants and young children (37.2 %) aged 0-4, 52 (40.3%) aged 5-11, and 29 (22.5%) aged 12-17. Five children without recorded ages were allocated the mean age of 7.64 years (SD 4.89). There were 69 family groups (at least one adult and one child) with 36.7% of children in single-parent families, and 29.3% with two parents. A further 3.6% are identified with three adult carers, presumably grandparents or aunts. Number of children ranged from one to six per family, with 39.9% of families having one or two children. The mean length of time in detention for all adults and children was 209.5 days (7 months), with a range of 90 to 390 days and SD of 62.36. This includes infants born into detention.

also indicate data entry errors. Oral translation of English language self-report measures by interpreters may have altered reporting. There are also minor age variations in versions of the SDQ, and in the disorderly circumstances, these were used randomly for children aged 3-17.

Statistical analyses

Demographic data was collated. K10 and SDQ data was entered into a database with incomplete data excluded. Total problem and specific symptom scores were analyzed. The SDQ was scored assuming parent report and analyzed using 5-factor analysis. Parent concerns in response to specific questions about infants were collated. Descriptive analysis of socio-demographic characteristics and mental health outcomes was undertaken to assess bivariate associations between parent and child indices. Multilevel analysis based on Actor-Partner Interdependence Model (APIM) and structural equation modelling was applied to examine for dyadic associations between parent and child outcomes.

Results

Kessler 10

There were 166 complete K10s: 139 for adults and 26 for teenaged children (aged 12-17). The prevalence of mental disorders was determined using the National Survey of Mental Health and Well-Being likelihood bands.[40] (Table 2). These results indicate very high rates of severe distress, with 83% of adults and 85.7%

TABLE 2: K10 results

	N	Percentage (%)
Parents/Carers	Total = 131	
Likely to be well (score <20)	1	0.7
Likely to have mild mental disorder (20-24)	9	6.9
Likely to have moderate mental disorder (25-29)	12	9.2
Likely to have severe mental disorder (30 or over)	109	83.2
Children (12-17 years)	Total = 35	
Likely to be well (score <20)	1	2.9
Likely to have mild mental disorder (20-24)	3	8.5
Likely to have moderate mental disorder (25-29)	1	2.9
Likely to have severe mental disorder (30 or over)	30	85.7

TABLE 3: K10 Anxiety/Depressive symptoms

Parent/Carer N=131 (P) Children 12-17 years N=35 (C)	P	C	P	C
Anxiety symptoms	None (%)		Most/All (%)	
Feeling nervous	12.2	5.7	87.8	94.3
Feeling so nervous that nothing could calm them down	13	14.3	87	85.7
Feeling restless or fidgety	14.5	8.6	85.5	91.4
Feeling so restless that they couldn't still	17.6	8.6	82.4	91.4
Depressive symptoms				
Feeling depressed	0.8	2.9	99.2	97.1
Feeling so sad nothing could cheer them up	3.1	2.9	96.9	97.1
Feeling that everything was an effort	7.6	5.7	92.4	94.3
Feeling worthless	9.9	8.6	90.1	91.4
Feeling tired out for no good reason	11.5	5.7	88.5	94.3
Feeling hopeless	13	5.7	87	94.3

of teenagers indicating severe disorder. Symptom responses were ranked highest to lowest with adolescents most often reporting *depressed, hopeless, and worthless*, while for adults it was *depressed, worthless, and tired for no good reason*. When K10 items for anxiety (items 2, 3, 5, 6) and depression (1, 4, 7, 8, 9, 10) were scored (Table 3), all participants met criteria for mixed anxiety and depression. The K10 does not enable PTSD to be differentiated.

Strengths and Difficulties Questionnaire (SDQ)

There were 70 complete SDQ for children aged 3-17. The age distribution shows 52 (74%) aged 3-11 and 18 (26%) aged 12-17. Although it is likely some SDQ for adolescents were self-reported, this cannot be distinguished and all were scored as parent-reported. Strong correlations have been found between self- and parent-reported SDQ in one study of refugee children.[41] Fifty percent of children had abnormal total difficulty scores and another 25.7% had borderline scores; in total, 75.7% of children had a high probability of psychiatric disorder (Table 4) Symptom distribution by five-factor analysis showed high rates of emotional symptoms with 71.5% abnormal and another 7.1% with borderline emotional symptom scores, indicating 78.6% of children had significant emotional symptoms. Conduct scores were lower with 39.85% of children with borderline or high conduct symptoms, 48.6% had borderline or high hyperactivity scores and 55.7% had abnormal peer problem scores. Prosocial behaviors were abnormal in 32.9% of children.

Infants and young children (aged 0-4)

The AHRC questionnaire asked: *Do you think your child's emotional and mental health has been*

Table 4: SDQ Scores

SDQ scores	N=70	Percentage (%)
Total difficulties score		
Abnormal (>17 total score)	35	50
Borderline (14-16 total score)	18	25.7
Normal (0-13 total score)	17	24.3
Emotional symptoms score		
Abnormal	50	71.5
Borderline	5	7.1
Normal	15	21.4
Conduct problems score		
Abnormal	25	35.7
Borderline	6	8.6
Normal	39	55.7
Hyperactivity score		
Abnormal	25	35.7
Borderline	9	12.9
Normal	36	51.4
Peer problems score		
Abnormal	12	17.1
Borderline	27	38.6
Normal	31	44.3
Prosocial behavior score		
Abnormal	16	22.9
Borderline	7	10
Normal	47	67.1

affected by being in detention? and *Do you have concerns about your child's development?* Responses and specific concerns were collated for the 48 children under five. (Table 5) Thirty-two (67%) parents identified concerns about the impact of detention on their infant's emotional or mental health and 11 (23%) identified concerns about development. The most frequent were socio-emotional symptoms including *nightmares and sleep problems, always worried, upset or sad, fighting with others, restless, agitated*. The most frequent developmental concern was *poor eating/low weight gain*.

Correlations

This study did not find correlations between length of detention and severity of psychological distress for adults or children. (Table 6) Nor were there significant associations within families between parent K10 and paired children's SDQ scores.

Discussion

Despite many limitations, this sample is arguably worth analysis and reporting because of the extremely limited health data about detained children and parents, the human rights implications of

Table 5: Concerns about infants and young children (aged 0-4)

Has your child's emotional and mental health been affected by detention?	
Yes	32 (67%)
No	2
No answer/not sure	14
Do you have concerns about your child's development?	
Yes	11 (23%)
No	4
No answer/not sure	33
Total	48
Specific concerns (ranked)	
Nightmares, sleep problems	18
Always worried/upset/sad	15
Fighting with others	10
Restless, agitated	8
Anxious, clingy, won't leave room	7
Poor eating/low weight gain	6
Not socializing	5
Not able to play or learn	4
Nail-biting/headaches/other	4
Toileting/constipated	3
Bedwetting/incontinent	3
Always shouting/ screaming	2
Self-harming/head banging	2
Not talking	2
Not crawling/walking	1

Table 6: Correlations

Correlations *LOD = Length of detention		Sig Value
Between child K10 and LOD*	Non-sig >.05	0.881
Between adult K-10 and LOD	Non-sig >.05	0.549
Between child SDQ and LOD	Non-sig >.05	0.223

the findings, and the impossibility of undertaking this research in conventional ways. It provides data on rates of probable mental illness, allows some description of symptom profiles, and attempts examination of data within families. Bias in the data is potentially in either direction, with under- or over-reporting of distress. It is of significant public interest that the mental health and human rights consequences of this aspect of Australian government policy are analyzed and reported in standardized, measurable ways.

As this study and the government's own data show, immigration detention has severe health and mental health consequences for the majority of detained adults and children. Rates of psychiatric disorder in the CI sample on the K10 dramatically exceed the 12-month prevalence in the general Australian population where affective disorders have a prevalence of 6.2% with 4.1% for depressive disorder, and anxiety disorder prevalence is 14.4% with PTSD at 6.4%.[42] Rates greatly exceed those reported in a large international meta-analysis of mental health of refugees and conflict-affected people, which found a prevalence of 30.8 % for depression and 30.6% for PTSD.[43] There is evidence of the adverse effects of detention on mental health post-release, but very little data on the mental health of currently detained asylum seekers. A small Australian study of detainees from one ethnic group using other standardized self-report measures found very high rates similar to this study, with 100% of detained adults meeting criteria for major depression and 86% diagnosed with PTSD.[44]

The high SDQ total problem scores for children in this sample more closely resemble Australian clinical than community populations. Rates of mental disorder in community samples are between 9% and 14%, while a study of 130 children referred to a mental health service (CAMHS) identified 85% of children with borderline or abnormal behavioral/emotional symptoms on SDQ.[45] High symptom scores in the CAMHS group showed 72% emotional, 78% conduct, 60% hyperactivity/inattention, 64% peer relationship problems with low prosocial scores in 38%.[46] Overall problem scores are similar (75.7% of the CI sample and 85% of the clinical group) with notably lower rates of conduct (38.9% compared with 78%) and hyperactivity/inattention (46% versus 60%) symptoms than the clinic population.[47]

Distress in the CI sample was higher than in children held in open European asylum centers or in the UK community. A study of 267 asylum seekers' children in open centers in the Netherlands found 50% of children aged 4-11 with significant symptoms, 38% in the abnormal range and 12% at borderline levels. Factors such as maternal mental health, parental loss, and family size were more important than length of detention.[48] A Danish study found that 26% of 246 children living with their families in open centers scored above caseness on total scores; 50% had significant emotional problems, 18% raised hyperactivity scores, 11% conduct problems, and 19% peer problems. Only 3% had abnormal pro-social scores.[49] A UK study of community-based migrant and refugee children using the SDQ found that 27% of refugee children, 9% of ethnic minority children and 15% of white children met case criteria.[50] Refugee children showed particular difficulties in emotional symptoms, consistent with the current study. Parents reported significant concern about their infants, and this vulnerable group deserves more attention in studies of displaced populations.

The lack of correlation between distress and time detained may represent a ceiling effect given the significant period detained and the pervasively high distress levels. The lack of correlation between parent and child distress may be explained by the statistical method (pairing one child with one parent). This is an inadequate measure of children's exposure to adult mental illness or disturbed family relationships. In closed detention, many interacting factors in the institutionalized environment alter family functioning and therefore the quality of parent-child interactions. In addition, children were in constant proximity to many adults, 83% of whom were likely to have a severe mental disorder. Potential protective factors outside the family, such as schooling, were largely absent. The available data does not enable analysis of children's exposure to specific or cumulative risks, including factors prior to their detention by Australia.

It is important to acknowledge that K10 scores indicate 14.3% of teenaged children and 17% of adults without significant symptoms. On SDQ, almost a quarter of children were not rated as of concern. There is no information, including about family factors, which might account for apparent resilience or under-reporting in adverse circumstances. Studies of refugees in the community identify belief systems, social support, and a range of psychological strategies as important, but literature on resilience and coping in detained child and adult asylum seekers is limited.[51] The UN General Assembly Human Rights Council recently re-affirmed "The right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and emphasizing that mental health is an integral part of that right."[52] The harms caused to child and adult asylum seekers are no longer denied by the Australian government, and instead repeatedly justified on the grounds of deterrence.[53] The use of mistreatment as deterrent contravenes the 1985 United Nations High Commission for Refugees (UNHCR) Guidelines on the Detention of Asylum Seekers, which explicitly state that this is contrary to the principles of international protection.

Conclusion

This study adds to the scientific literature, witness reports, and the Australian government's own evidence of the profound negative consequences of detaining asylum-seeking children and families. There are few studies of families during prolonged immigration detention and fewer that include children under 5 years. A majority of parents had concerns about their infant's health and /or development. K10 and SDQ scores indicate extreme rates of psychological distress and probable disorder in children and adults and teens with co-morbid anxiety and depression at clinical levels. Detention may have specific psychological impacts on children, resulting in higher rates of emotional symptoms but lower hyperactivity and conduct scores than in clinical groups. The profound access limitations and lack of independent health care provision and monitoring make detailed analysis of potential contributing and cumulative risk factors impossible.

Australia's current immigration policies violate detainees' human rights in multiple ways, including their right to health, by causing severe psychiatric distress and disorder in adults and children. Untreated or inadequately treated mental illness has ongoing consequences and increases the risk of self-harm and suicide. This has implications for the immediate and longer-term care of asylum seekers and further highlights the harm caused. The acknowledged methodological limitations of the study are a consequence of the practical, political and ethical obstacles to undertaking research in conventional ways with this extremely vulnerable population. Australia's harsh immigration and border protection regime is maintained and defended in callous disregard for the people who are harmed. Justification on the basis of deterrence represents a further breach of our humanitarian obligations, raising concern that these practices amount to torture of those detained indefinitely. The findings of this study have scientific, human rights, and undeniable political implications.

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