

Impact of punitive immigration policies, parent-child separation and child detention on the mental health and development of children

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ABSTRACT

In April 2018, the US government introduced a 'zero tolerance' illegal immigration control strategy at the US-Mexico border resulting in the detention of all adults awaiting federal prosecution for illegal entry and the subsequent removal of their children to separate child shelters across the USA. By June 2018, over 2300 immigrant children, including infants, had been separated from their parents for immigration purposes. Media reports and scenes of distraught families ignited global condemnation of US immigration policy and fresh criticism of immigration detention practices.

Detention of children for immigration purposes is known to be practised in over 100 countries worldwide, despite a significant body of research demonstrating the extensive harm of such policies. This review explores and contextualises the key potential impacts of family separation and detention of children for immigration purposes including damaged attachment relationships, traumatisation, toxic stress and wider detrimental impacts on immigrant communities. As such, it is critical for host nation governments to cease the practice of family separation and child detention for immigration control and promote postmigration policies that protect children from further harm, promote resilience and enable recovery.

INTRODUCTION

In recent months, the Trump administration has been subject to damning condemnation from child health and human rights experts for their pursuit of a 'zero tolerance' immigration strategy requiring the detention and federal prosecution of all adults apprehended for illegal entry at the US-Mexico border, including those seeking asylum.^{1 2} As US law does not permit child detention in federal jail, the consequences of such parental arrests included the enforced removal of accompanying children to separate detention facilities. Between April and June 2018, over 2300 immigrant children, reportedly including preverbal, breastfed infants were relocated to separate child detention shelters across the USA to await resolution of their parent's case and hopeful, but not guaranteed, reunion.³

In late June 2018, after extensive public and political outrage President Trump signed an executive order ending the policy of separating children from their parents at the US-Mexico border. Promises of ongoing 'zero-tolerance', prosecution of adults and family detention remained. Subsequent reunification of separated families has been hampered by a grievous lack of foreplanning and complex interactions with parents regarding child return and repatriation. By August 2018, reports estimated that 700 children, including 40 children under the age of 4 years remained separated from their parents.⁴

The USA is not alone in the punitive management of immigrant children. Over 100 countries are known to detain children for migration-related reasons including the UK, Australia and Canada despite emphatic criticism of the practice as a child rights violation, in contravention of the principle of the best interests of the child and significantly detrimental to child well-being.⁵ The Royal College of Paediatrics and Child Health,⁶ the American Academy of Pediatrics,⁷ the Canadian Paediatric Society,⁸ the American Medical Association,⁹ the Canadian Medical Association¹⁰ and the International Society for Social Pediatrics & Child Health¹¹ all recently produced strong statements condemning the systematic splitting of immigrant families, bringing concerns over immigrant child detention and welfare in the USA and their own nations to the fore.

This article considers the recent US immigration practice as a case example and context to explore the key potential impacts of punitive immigration policies on the well-being of affected children, the wider sequelae of hostility towards immigrant families and a call to advocate for children subject to detention and detrimental immigration policy.



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Global child migration and detention

In 2016, the United Nations High Commission for Refugees estimated that 50 million children had migrated across country borders or were forcibly displaced. Twenty-eight million (1 in every 80) children fled violence and insecurity, a figure that has more than doubled between 2005 and 2015.¹² Twelve million of these children were recorded as refugees or asylum-seekers. Sixteen million children were internally displaced within their home country borders. A further 7 million children had been displaced due to natural disasters. In 2015 and 2016, at least 300 000 children were registered unaccompanied or separated as they crossed borders in over 80 countries.¹³

No validated data are available regarding the number of children in immigration detention worldwide at any given time. The number of children impacted per day through personal or parental detention is estimated in millions.¹⁴ In many countries, immigration detention remains synonymous with widespread human right violations, lamentable conditions, child maltreatment, abuse and torture.¹⁵ Lack of transparency regarding immigration detention is widespread, severely hampering monitoring of practice and informed public and policy debate.¹⁶

There is no research available evidencing child detention as beneficial to children or functioning as a successful immigration control strategy.

At the end of May 2018, the US Department of Health and Human Services reported 10 773 unaccompanied immigrant children in its custody, including the 20% swell in numbers since April 2018 due to enforced separation of children from parents at the US-Mexico border.¹⁷ In 2013, Australia experienced a large surge of illegal maritime arrivals leading to the detention of 2000 children.¹⁸ As of April 2018, 7 children under the age of 18 years were in immigration detention in Australia with 22 children in the highly controversial offshore Nauru Regional Processing Centre.¹⁹ In Canada, 155 minors have been kept in detention facilities in the past year. While Canada separates children from parents only as a last resort, by keeping immigrant children in adult detention facilities with their mother (fathers are detained separately) as 'housed minors' rather than detainees, child rights remain violated.²⁰ In the UK, 42 immigrant children were detained in 2017.²¹ Data on child immigration detention across Europe are poorly aggregated leaving the situation unclear. Concern continues to mount regarding the number and condition of child detainees in Greece, with Save the Children reporting 'appalling conditions' driving a mental health crisis.²²

While few countries can take the moral high ground regarding the detention of children for immigration purposes, the systematic separation and detention of immigrant families en masse, without warning or opportunity to challenge, is a phenomenon specific to recent US Trump administration policy.²³

Illegal immigration at the US-Mexico border

Immigrants detained at the US-Mexico border are primarily asylum-seekers from Guatemala, Honduras and El Salvador; chronically destabilised regions plagued by grave levels of human rights violations, insecurity, poverty, drug cartel infiltration, violence and corrupt justice systems. Criminal gangs target children and mechanisms of exploitation and control are notoriously brutal.²⁴ Migration through Mexico to the USA is equally gruelling and perilous with immigrants reporting violence, kidnapping, sexual and physical abuse, human trafficking, extortion and ill treatment by officials.²⁵ Access to adequate shelter, nourishment and medical care is precarious. As immigrant children reach the US-Mexico border, their compounding exposures to detrimental social determinants of health and cumulative adverse experience places them at eminent risk of developmental, mental and physical harm.²⁶

Child immigration detention in the USA

Concerns regarding child detention in the USA are not new. In 2017, the American Academy of Pediatrics reported that the basic standards of care for immigrant children in detention were not met. Egregious conditions in processing centres included inadequate bathing and toilet facilities, constant light exposure, children sleeping on concrete floors, confiscation of belongings, insufficient food, denial of access to thorough medical care, lack of mental health support plus physical and emotional maltreatment. Health assessments are performed without parental presence and medical history.²⁷

Recent reports of conditions for detained children also include indiscriminate use of the 'no touch' rules designed to prevent inappropriate physical contact.²⁸ While such rules may have their place in safeguarding unaccompanied adolescents, depriving very young children of physical comfort serves to significantly heighten distress. Such circumstances clearly increase the risk of undetected, undertreated, exacerbated and new-onset health conditions. Research is clear however, that even with the provision of safe and sanitary environments the separation of a vulnerable child from their parents may carry severe consequences.²⁹

The trauma continuum

Childhood trauma occurs when a child is in a situation that induces a sense of intense fear and helplessness.³⁰ Traumatic stress responses are best viewed as a continuum (table 1)—nuanced and dependent on a range of features of the traumatic event(s), internal child resilience and the post-trauma environment of the child.³¹ Type I trauma occurs primarily after time-limited exposure to an extreme event such as a road traffic accident, recovering without significant injury in an environment of supportive adult relationships. Type II trauma is characterised by repeated, prolonged trauma exposure such as sexual abuse in the home.³² Type III trauma occurs when a child experiences multiple, pervasive, prolonged,

Table 1 The trauma continuum

Type I trauma	Type II trauma	Type III trauma
Single incident trauma	Multiple traumas	Multiple pervasive traumas from an early age that continue over a length of time



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violent actions initiating at an early age (even in utero—such as domestic violence during pregnancy), creating an extremely hostile environment for development.³³ It is vitally important to recognise different forms and severity of childhood adverse experience as a guide to the extent of traumatic stress and damage to the developing child's brain.

It is the combination of conscious and deep, subconscious experiences of threat that drives the subsequent neurological and physical damage caused by childhood adversity and trauma. When a lack of safety or threat is perceived, primary neural activity in the brainstem initiates the 'fight, flight or freeze' response, promoting the outpouring of stress hormones epinephrine and cortisol that prepare the physical body to respond in a protective manner. During intense fear, the rational considerations of the prefrontal cortex are bypassed leading to behaviour profoundly driven by the subconscious. Children's brains have a remarkable level of neuroplasticity, and in situations of multiple, prolonged, pervasive adversity their brain will chronically adapt to a level of functioning that seeks to preserve and protect life at the expense of all peripheral learning and relationship.³⁴ Such children may develop complex patterns of protective responses that can include hyperarousal—hyper-vigilance, agitation, flashbacks and emotional reactivity, or hypoarousal—dissociative responses, emotional numbing (self-harm may be used as a tool to 'feel alive'), passive compliance and poor access to cognitive functioning.³⁵ The well-known diagnosis of post-traumatic stress disorder fails to capture the wider developmental out-workings of complex trauma, including the impact on preverbal children and it should not be considered the only marker of trauma response.³⁶

Threatened attachment

The separation of children from their parents threatens the attachment bond, forming an additional root of fear and lack of safety. This deep, enduring affectional bond between a child and caregiver begins in infancy and is critical to the child's inherent sense of safety and protection. Neurologically, attachment relationships drive the brain development foundational for subsequent physical, emotional, social and cognitive maturation. When parents are removed from a child's life suddenly and without adequate support, the attachment relationship is threatened.³⁷

Children tend to respond to separation from their caregiver in three fluid phases. First, children enter an acute

phase of protest characterised by fear, distress, crying and urgent seeking of their caregiver that may last from a few hours to days. As the length of separation continues, children enter a phase of despair during which crying weakens, movement lessens and children reject the approach of alternative adults. With prolonged parental absence, children may become passively compliant with care staff, giving the appearance of having 'settled in' to their new environment. Disturbingly, this can signify that the child has detached from the parents and is now living in a perceived state of 'fear without resolution'. Children reunited while they are in the early separation protest phase usually fare well. Children in despair may respond to the reappearance of their parent with hostility or ambivalence, taking many weeks to rebuild their bond. Children who have detached from their parents may reject their approaches or treat them as strangers.²⁹ Additionally, when children interpret themselves as 'abandoned' by parents, they may develop a profound sense that they have done something wrong to cause their caregiver to leave, igniting shame and complex emotions that can damage the lifelong relationships with themselves and others.³⁸

Immigration detention also grossly undermines parenting capacity and parental mental health, whether separated or in family detention settings.³⁹ This can further damage the attachment relationship, adding to the precarious conditions for children in need of a stable, caring adult relationship to support them in trauma processing.

Through the lens of attachment, it has been concerning to observe the recorded reunions of parents and children following immigration release in the USA. While some reunions have been joyful, others evidence warning flags of significant attachment damage.⁴⁰

Toxic stress

The chronic pounding of stress hormones through the physical bodies of children risks becoming toxic, driving architectural organ damage with lifelong developmental and health sequelae. Stress hormone cascades activate inflammatory and immune changes, considered to be a response to the increased risk of physical injury and healing required in situations of danger. Such processes drive the development of disease and disorder. A child with high adversity exposure has triple the lifetime relative risk of lung cancer, 3.5 times the relative risk of ischaemic heart disease and up to a 20-year reduction in life expectancy.²⁶ Cancers, diabetes, autoimmune disease

Table 2 Disease and disorder outcomes associated with multiple adverse childhood experiences and toxic stress (not exhaustive)

Behaviour with significant health consequences	Mental health	Social inclusion difficulties	Chronic disease and organ damage
Excessive food consumption leading to high body mass index and obesity	Mental ill health and psychiatric diagnoses Anxiety	Harms to life prospects including: education, employment, poverty and healthy relationships	Cancer Heart disease
Smoking	Depression		Respiratory disease
Heavy or problematic alcohol use	Suicidality		Liver or digestive disease
Problematic drug use	Self-directed and interpersonal violence		Diabetes mellitus
Sexual risk taking and teenage pregnancy	Poor life satisfaction		

Adapted from Hughes *et al.*⁴¹

and numerous other health problems (table 2) are associated directly with toxic stress (not only secondary to unhealthy coping habits, ie, smoking). Worryingly, the outcomes most strongly linked with childhood adversity impact the next generation; notably, substance use, violence and mental illness.⁴¹

Given our understanding of the background levels of complex, intergenerational adverse circumstances faced by Central American families seeking asylum in the USA, there is considerable concern about the levels of child traumatising and mental health needs prior to US entry.⁴² For such children to then be separated from their primary caregivers and resilience relationships, detained for unknown duration in unsuitable child detention facilities and deprived of relational environments to support resilience and stress response stabilisation, we are witnessing a perfect storm for the development of toxic stress and severe, complex, type III trauma.

Wider impacts on immigrant health

Hostile policy and rhetoric regarding immigrant families can create a form of structural racism rendering immigrants (particularly those entering illegally) racialised, devalued, dehumanised ‘others’,⁴³ with wider society increasingly normalised to the stereotyping and suffering of this group. This in turn impacts the social determinants of health for immigrants via multiple pathways that increase and drive cyclical inequalities in health and well-being.⁴⁴ Hostile policies impact those directly affected and extend influence over wider immigrant communities, of whom children are some of the most vulnerable.⁴⁵ Patterns of ‘othering’ of societal groups have fed many of the most aggressive acts in human history.⁴⁶

In the USA, Hispanics (including Central Americans) are the largest minority ethnic group, projected to represent 29% of the US population by 2060. They are also the youngest ethnic group with 32% of Hispanics under the age of 18 years and 26% between the ages of 18 and 33 years. Hispanics remain disproportionately affected by

poor conditions of daily life, the social determinants of health (SDH) shaped by complex structural and social factors including immigration status, income and health policy. SDH also exert health effects on individuals via chronically activated stress pathways, eliciting biological processes aligned with toxic stress. Significant physical and mental health disparities have been detected compared with white peers yet rates of health insurance and utilisation of health services remain disproportionately low. While the causes are complex and the group heterogeneous, fear of stigmatisation and deportation are cited as key reasons why Hispanic immigrant children have unmet health needs.⁴⁷

Recent US policy decisions risk further Hispanic isolation, stress and disengagement with health services creating substantial health inequalities for immigrant children.

Resilience, recovery and prevention of further harm

While it is recognised that childhood trauma, abuse and adversity can have profoundly damaging effects on children’s health and development, decades of research regarding the resilience of children has evidenced that many children are indeed, given time, able to overcome serious threat and adversity, particularly when protective relationships and safety are restored.^{48 49} Resilience has been poetically described as an ‘ordinary magic’—a normal, dynamic, positive process of adjustment and development in spite of severe stressors and adverse experiences.^{48 49} Refugees, as individuals who have experienced profound, complex, multilayered threats and hardships are frequently described as ‘remarkably resilient’—holding the ability and determination to overcome and lead productive, healthy lives that contribute significantly to their local communities and host nations.⁵⁰

The ability of a child to outwork their inherent capacity for resilience can be impacted by many factors including key social and environmental influences that compromise or enhance the protective systems around them. Host countries have significant opportunities to mitigate

further harm to asylum-seeking and refugee children by developing postmigration policies, processes and environments at individual, family and community levels that are trauma-informed and protective.⁵¹ Key considerations include the critical need for each child to have access to safety, protection and health services. This includes access to culturally competent psychological and psychiatric support where necessary for children deeply wounded and developmentally disrupted by trauma. At family level, the reunification of parents and children must be prioritised and expedited with ongoing support for families to remain intact. At community level, asylum claims must be resolved as quickly as possible to enable stable settlement and integration. Protracted bureaucratic processes, instability, delays and frequent relocations negatively impact parent and child mental health. Concerted efforts need to be made to reduce inequalities and inequities of access to education, health, social, economic and political resources.⁵¹

Conclusion: a call for the end of family separation and child detention

Separation of vulnerable immigrant children from their parents on the background of chronic and acute adversity creates a perfect storm for attachment damage, toxic stress and trauma. Children in immigration detention remain at significantly increased risk of physical, mental, emotional and relational disorders in the short and long term. Hostility towards immigrants raises further barriers to health service engagement and risks increasing the health disparities and number of children living with unmet health needs.

Host countries have a decisive opportunity to reduce harm and promote the resilience and recovery of traumatised children by developing protective postmigration policies and processes. It is crucial that the USA and other countries practising child immigration detention expedite the reunion of immigrant families and end child detention. It is also critical for policy leaders to recognise that family detention is not a 'kinder' alternative and the 'othering' of immigrants and normalisation of suffering should never be tolerated.⁵² All forms of immigration detention are highly detrimental to children and adults and the many effective alternatives must be considered.⁵³ Paediatricians, healthcare professionals and researchers must continue to advocate for children and families exposed needlessly to immigration detention by bringing robust evidence of harms to the policy debate. We must also engage with policy makers regarding health-promoting practices, enabling all children to thrive and contribute positively to society.

We must urge our leaders to end detention in our homelands, promote justice and enjoyment of child rights for all children and call on the USA to end its punitive practice of child and family detention.

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