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DISCUSSION PAPER SERIES**

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up in asylum systems**

Robert Mooney,
Geary Institute for Public Policy,
University College Dublin

Geary WP2015/11
May, 2015

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A model supporting research on children growing up in asylum systems

Robert Mooney

Abstract: Recent media reports and public policy debates have highlighted concerns regarding the impact on children of growing up in Direct Provision Centres (DP) in the asylum system in Ireland. This system has been criticised for the poor quality of the accommodation in which asylum seekers reside and the inadequate provision of resources, services and supports to meet their basic needs. Children's development is significantly influenced by their environment. The risks and opportunities experienced at this stage of life can radically influence their social skills, mental wellbeing, and their physical health (Bronfenbrenner, 1979). Evidence suggests that the children of immigrant populations face additional challenges of integration into their host societies (Ager and Strang, 2004). This review of national and international research suggests that these issues are compounded in the case of children growing up in asylum systems. As some children spend between four 4 and eight 8 years living in these institutions, it is critical to assess the developmental consequences of growing up in DP. This paper examines the national and international legislation governing asylum systems, provides an overview of the Irish Direct Provision system and suggests a model under which these cases may be analysed across different societal levels.

1. Introduction

An asylum-seeker is someone who has submitted a claim for refugee status but whose claim has not yet been definitively evaluated. In Ireland applicants for asylum are provided for under the Direct Provision (DP) system, which consists of accommodation, basic food provision, and weekly allowances of €19.10 per adult/ €9.60 per child. These DP centres include old hostels, hotels, holiday homes and a small proportion of self-catering and chalet style accommodation dispersed across the country. Much of this accommodation is reported to be in poor condition and overcrowded. The average duration in DP is almost 4 years but some residents wait over 14 years for a decision. Currently there are over 4,600 individuals resident in DP centres in the asylum process or seeking leave to remain. An estimated 1,600 of these are children. Children of asylum seekers, and children born in the asylum system who are Irish citizens, face considerable adversities. While they have the right to legal aid, social care and medical care, and children under 18 have the right to education, they are denied many basic rights, and face social, cultural, economic and legal barriers which isolate them from Irish society. These issues directly affect these children, as well as undermine the capacity of their parents to care for them.

Our review of the research on DP in Ireland in Section 3 indicates wide-ranging concerns about the quality of accommodation; the incidence of poverty; exclusion from the labour market; limited access to education; quality and cultural appropriateness of food and social exclusion. These conditions, combined with victimisation, discrimination and uncertainty about the future may lead to anxiety, boredom stress and depression and may undermine parent's ability to adequately fulfil parenting roles. This combination of adverse conditions may have negative consequences for children's wellbeing and development.

This review of the national and international research points to consistent issues faced by asylum seekers in all countries including poverty, poor quality food, substandard accommodation, and elevated risks of mental and physical ill-health. In the case of children this may lead to developmental problems and difficulties in the transitions into adulthood for children growing up in these systems.

A biopsychosocial model of health and wellbeing initially proposed by George Engel (1977) and developed by (Bronfenbrenner, 1979) provides a basis by which to explore the interconnections between a child's physical and mental health, their access to resources and the social setting in which they live and grow, and their behaviour and suggest how risks to these indicators of wellbeing may positively or negatively affect their development. It also highlights the embeddedness of the individual, social institutions and societal ideologies in influencing the development of children, and adults. This paper develops an adaptation of the Bronfenbrenner model to support the measurement of the impact of living in residential centres for asylum seekers upon the wellbeing and development of children. This paper: a) situates the case of children growing up in residential centres for asylum seekers in the human rights context

through relevant international, European and Irish conventions, legislation and treaties; b) reviews the Irish asylum system in this context; c) presents current models of childhood development and frameworks for migrant integration; d) provides a systematic review of the national and international research which has documented and analysed the experiences of asylum seekers living in these systems and identifies particular challenges the children growing up in these systems face and e) suggests a model under which these cases may be analysed across different societal levels.

1.1. International approaches to the issue of asylum seekers and refugees

According to the United Nations Refugee Agency¹ the terms asylum-seeker and refugee are often used incorrectly to relate to the same individual. The *United Nations Convention (1951) and the Protocol relating to the Status of Refugees (1967)*² to which Ireland is a signatory, defines a refugee as:

“owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.”

Further it maintains that contracting states should accord refugees the same rights as nationals in relation to the freedom from discrimination on the basis of race, religion or country of origin³; their right to legal assistance⁴, their right to engage in wage-earning employment⁵, their rights to elementary education⁶, and their labour rights and the right to social security⁷.

National asylum systems determine which asylum-seekers qualify for international protection and are awarded refugee status, those whose claims cannot be authenticated yet may be granted leave to remain on humanitarian grounds, and those who are deemed not to be in need of international protection and can be returned to their countries of origin. Ireland has ratified the European Communities (Eligibility for Protection) Regulations 2006 which gives effect to Council Directive 2004/83/EC on minimum standards for the qualification and status of third country nationals or stateless persons as refugees or as persons who otherwise need international protection and the content of the protection granted (2004)⁸ and agrees to the provision of rights of those who have officially been granted refugee status.

¹ <http://www.unhcr.org/pages/49c3646c137.html>

² <http://www.unhcr.org/3b66c2aa10.html>

³ Article 3

⁴ Article 16

⁵ Article 17

⁶ Article 22

⁷ Article 24

⁸ <http://www.un.org/en/documents/udhr/>

The EU Council Directive 2003/9/EC *Laying down minimum standards on the reception of asylum seekers*⁹ aims to ensure that asylum applicants have a dignified standard of living and that comparable living conditions are afforded them in all EU Member States. The Common European Asylum System (CEAS)¹⁰ pursues common minimum standards for asylum seekers and seeks to raise the standards of protection among the European Member States. The new *Asylum Procedures Directive* legislation, which stems from the CEAS and was adopted in December 2005¹¹, aims to create a coherent system which ensures that asylum decisions are made more efficiently and more fairly and that all Member States examine applications with a common high quality standard. The directive also outlines clearer rules on how to apply for asylum. EU accession treaties allow for opt outs of certain EU Directives without the requirement of a rationale. Ireland has not opted-in to the EU Council Directive 2003/9/EC nor the CEAS.

1.2. Irish Law and Asylum Seekers

The Irish constitution recognises fundamental rights under articles 40 to 44¹² to be co-extensive to include not only those who have access to constitutional rights of equality, socio-economic rights, the right to work and right to family life, but those who lawfully reside within the state.

The Refugee Act 1996 is the principal national legislation dealing with applications for asylum in Ireland. The Irish Naturalisation & Immigration Service (INIS) was established in 2005 in order to provide a 'one stop shop' in relation to asylum, immigration, citizenship and visas. The INIS is responsible for administrative functions of the Minister for Justice and Equality in relation to asylum, immigration (including Visas) and citizenship matters. For the purposes of processing asylum applications, reviewing appeals, and the co-ordination of services such as reception and accommodation aspects, the Government has established, respectively, the: a) The Office of the Refugee Applications Commissioner (ORAC); b) the Refugee Appeals Tribunal (RAT) and c) the Reception and Integration Agency (RIA) (established in April 2001).

The Immigration Act 2003 requires carriers to carry out basic checks to ensure that passengers from outside the Common Travel Area (UK, Northern Ireland, the Channel Islands and the Isle of Man) are in possession of valid documentation necessary for entry into the State. The Immigration Act 2004 makes provision for the appointment of immigration officers and criteria for permission to land. The Act empowers the Minister to make orders regarding visas and approved ports for landing, and imposes limits on

⁸ <http://www.refworld.org/pdfid/4157e75e4.pdf>

⁹ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2003:031:0018:0025:EN:PDF>

¹⁰ See http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/asylum/index_en.htm, http://ec.europa.eu/dgs/home-affairs/e-library/docs/ceas-fact-sheets/ceas_factsheet_en.pdf and <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2008:0360:FIN:EN:PDF>

¹¹ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2005:326:0013:0034:EN:PDF>

¹² <http://www.irishstatutebook.ie/en/constitution/>

the duration of a non-Irish national's stay¹³. The Immigration and Residence Bill 2010 modifies certain aspects of the law relating to the entry into, presence in and removal from the state of certain foreign nationals and others, including foreign nationals in need of protection from the risk of serious harm or persecution elsewhere.

Although these acts exist to define the parameters under which an immigrant can enter and remain in Ireland, there is no legislative basis for Direct Provision in Ireland with the current system being based on administrative decisions and Ministerial Circulars (Joyce & Quinn, 2014; Thornton, 2013).

Mullally and Thornton (2009) argue that the Irish state has increasingly been at the centre of controversies involving tensions between state interest and immigrant control. The interests of the child have been at the heart of these debates. They argue that the Irish courts give only limited weight to claims that it is in the best interest of the child upon which this implementation of this legislation should be based.

2. The Asylum System in Ireland

2.1. Direct Provision in Ireland

Direct Provision is the state system designed to meet the basic needs of food, accommodation and assistance for those seeking asylum in Ireland¹⁴. The numbers applying from asylum increased from a low of 9 per annum in 1991 to a peak over 11,000 in 2002 and slowly dropped off to less than 8,000 in 2003 less than 4,000 in 2007 to less than 1,000 in 2012. At the end of 2013, there were an estimated 4,600 individuals resident in 34 DP centres distributed across the country. 26 out of 34 house over 1,600 children¹⁵ or over one-third of the total asylum seeker population. Of the asylum population the nationalities include individuals from Nigeria (27%), Democratic republic of Congo (9%), Pakistan (7%), Zimbabwe (6%), South Africa (3%), Cameroon (3%), Ghana (3%), Afghanistan (3%), Somalia (3%), Algeria (2%) and other (34%). The accommodation centres at which the vast majority of asylum seekers reside are mainly hotels, hostels and in one case an old holiday park¹⁶. Of these centres 38% are urban, 14% are suburban, 20% are beyond 3km, 21% are between 5.1 and 10km, and 6% are over 10km from an urban centre¹⁷.

Direct Provision provides asylum seekers with accommodation, food, healthcare, and small allowances (Joyce & Quinn; 2014). Their weekly stipend is €19.10 for adults, and €9.60 per child¹⁸. An exception payment can be made of €100 per annum upon request to cover specific items such as school books and uniforms. Those under 18 are provided with free primary and secondary education. They also receive a free medical screening

¹³ http://emn.ie/cat_search_detail.jsp?clog=4&itemID=41

¹⁴ http://www.ria.gov.ie/en/RIA/Pages/Direct_Provision_FAQs

¹⁵ <http://www.ria.gov.ie/en/RIA/RIADec%28A4%292013.pdf/Files/RIADec%28A4%292013.pdf>

¹⁶ Ibid

¹⁷ Ibid

¹⁸ <http://www.ria.gov.ie/en/RIA/RIA%20Child%20Protection%20Policy%20for%20Accommodation%20Centres.pdf/Files/RIA%20Child%20Protection%20Policy%20for%20Accommodation%20Centres.pdf>

service and free legal aid. They do not have the right to engage in employment, and have no labour rights or rights to social security, which are provided to those who have been declared refugees¹⁹. The average duration in DP is almost 4 years, but many asylum seekers wait over 8 years, and some as long as 14 years, before a final decision regarding their application for refugee status is made²⁰.

The Irish state centrally coordinates the reception and asylum accommodation through the Reception and Integration Agency (RIA). The finances for the operation of the asylum system are centrally administered, while the operational management of facilities are subcontracted to commercial third sector service providers. The assignment of asylum seekers to residential centres is not legislated for in Ireland, rather it takes the form of administrative arrangements. Dispersal across the national territory to these centres is mainly guided by the prevention of overburdening individual services in any specific region, and is monitored by an inflow/remaining accommodation capacity procedure (Arnold, 2013). Unaccompanied minors (UAMs) are the exception and can be accommodated in separate protection zones in reception facilities and are the responsibility of the Health Service Executive (NíRaghallaigh, 2013; EMN Unaccompanied Minors–EU comparative study, 2010²¹).

A very small proportion of asylum seekers (less than 2%) live in self-catering accommodation²². While there are DP facilities specifically designated for single people and those for families, there is no dedicated procedure by which a specific accommodation type is allocated to different asylum seekers, or families, with different needs.

2.2. Criticisms of the Irish Asylum System

Direct Provision in Ireland has received widespread criticism nationally and internationally. In 2011 the United Nations Committee on the Elimination of Racial Discrimination (UNCERD) expressed concern at the:

“negative impact that the policy of ‘direct provision’ [in Ireland] has had on the welfare of asylum-seekers who, due to the inordinate delay in the processing of their applications, and the final outcomes of their appeals and reviews, as well as poor living conditions²³, can suffer health and psychological problems that in certain cases lead to serious mental illness”²⁴.

¹⁹ <http://www.irishstatutebook.ie/1996/en/act/pub/0017/>

²⁰ <http://www.ria.gov.ie/en/RIA/RIA%20Child%20Protection%20Policy%20for%20Accommodation%20Centres.pdf/Files/RIA%20Child%20Protection%20Policy%20for%20Accommodation%20Centres.pdf>

²¹ http://emn.ie/files/p_20100716105712unaccompanied%20minors%20synthesis%20report.pdf

²² Ibid

²³ http://ec.europa.eu/dgs/home-affairs/what-we-do/networks/european_migration_network/reports/docs/emn-studies/emn_second_focussedstudy2013_organisation_of_reception_facilities_final_version_28feb2014.pdf

²⁴ CERD, Concluding observations of the Committee on the Elimination of Racial Discrimination, Seventy-eighth session, 14 February – March 2011: http://www2.ohchr.org/english/bodies/cerd/docs/co/Ireland_AUV.pdf

While asylum seekers are not refugees, children living in DP are not necessarily themselves claiming refugee status independently of their parents²⁵. Some children living in DP may also have been trafficked and have no control over their circumstances (Arnold, 2013: 12). Thornton (2013) argues that there has been a systematic withdrawal of social rights and the traditional supports of the welfare state denying the adult, and child, asylee the right to be self-sufficient on the basis of discouraging new asylee's from seeking entrance to Ireland. Other controls also separate asylees from the majority population. This, he argues, places Ireland in breach of European *Convention on the Rights of the Child* where 'parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children' (Article 18.2²⁶) and contradicts the *Children First National Guidelines for the Protection and Welfare of Children*²⁷

This is supported by the *Fifth Report of the Special Rapporteur on Child Protection*²⁸ in Ireland which highlights the need for research on:

“the potential or actual harm which is being created by the particular circumstances of their residence [such as children living in direct provision] including the inability of parents to properly care for and protect their children and the damage that may be done by living for a lengthy period of time in an institutionalised setting which was not designed for long term residence” (Shannon, 2011).

2.3. Direct provision in Ireland compared to other EU countries

The European Migration Network (EMN) (2014) report *The Organisation of Reception Facilities for Asylum Seekers in Different Member States*²⁹ is a study of asylum and reception facilities and services in twenty-four European Union Member states³⁰. According to the CEAS all Member States should offer an equivalent standard of treatment for asylum seekers. The report finds, however, that the facilities differ greatly between states and within states at the local level. In particular there is a need for the standardisation of vulnerability assessments at the reception stage. This includes assigning them to appropriate accommodation, the effective and expedient processing of their claims, and effective and implementable return/integration strategies after a decision is made³¹. The report finds that most member states, with the exception of

²⁵ <http://www.irishrefugeecouncil.ie/>

²⁶ http://www.childrensrights.ie/sites/default/files/submissions_reports/files/UNCRCEnglish_0.pdf

²⁷ <http://www.dcy.gov.ie/documents/Publications/ChildrenFirst.pdf>

²⁸ <http://www.dcy.gov.ie/documents/publications/5RapporteurRepChildProtection.pdf>

²⁹ http://ec.europa.eu/dgs/home-affairs/what-we-do/networks/european_migration_network/reports/docs/emn-studies/emn_second_focussedstudy2013_organisation_of_reception_facilities_final_version_28feb2014.pdf

³⁰ Austria, Belgium, Cyprus, Czech Republic, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Netherlands, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, United Kingdom, Norway

³¹ The report defines the following categories of asylum applicants under the Dublin II Regulation ; in admissibility procedures (reception centre or initial reception centres); in accelerated procedures; vulnerable persons; unaccompanied minors (UAMs, including those who have exhausted the asylum

Ireland, France, Hungary, Lithuania and Slovenia provide tailored accommodation for vulnerable persons.

The report also finds that many member states³² provide financial allowance for food, clothing and other expenses, while Ireland provides food and accommodation and 'pocket money'. Clothing is provided in-kind³³ and through financial allowance³⁴ in many member states. In Ireland applicants must make an application to the community welfare for an exceptional needs payment. Ireland has a minimum standard of 11m³ space for each resident residential centres of asylum seekers, but it is stipulated that this is subject to the physical limitations of the premises original use. The supervision rate, or the number of supervisory staff per asylum seeker, is not specified in Ireland and varies between individual centres. Most of the member states, including Ireland, report on providing some leisure facilities at the centres. The provision of these facilities varies greatly between states and on a regional level. Examples include language, integration course, IT courses and internet access, sports and excursions (Austria), gymnasium access (Latvia and the Slovak Republic), sewing and cooking (Belgium), library room (Cyprus), vegetable gardening (Estonia) film, information sessions on life in France, the health system, health prevention (France), crafts (Lithuania), workshops (Italy and Luxembourg), and open kitchen access and voluntary work (Portugal). In Ireland the report merely notes that facilities vary greatly depending on the centre.

In addition, only a very small percentage (8.6%³⁵) are granted asylum or leave to remain in Ireland. This is significantly lower than the 25.2% average across the EU. Only Luxembourg (1.8%), Greece (4.9%), and Cyprus (5.2%) rejected a higher percentage of asylum application's than Ireland among all of the EU Member States³⁶.

3. Case study analysis: research examining conditions and experiences of asylum seekers

The following presents a review of the Irish and international research conducted with residents living in asylum systems.

3.1. Irish Studies

In total 12 research projects and academic papers which review existing data were examined. The studies involved small scale quantitative (Collins, 2002; Clarke, 2006) and qualitative data collection (Stewart, 2006; Healy, 2007; Vanderhurst, 2007; Ni

procedure); asylum applicants who have lodged an appeal procedure or have applied for a subsequent procedure; those who have received a positive decision and are awaiting formal declaration of refugee status as well as rejected applicants and who may or may not have been granted humanitarian leave to remain.

³² Estonia, France, Greece, Latvia, Netherlands, Sweden, United Kingdom, and Norway

³³ Belgium, Czech Republic, Estonia, Hungary, Lithuania, Portugal, Slovak Republic, Slovenia

³⁴ Austria, Finland, Netherlands, Poland, Spain, Sweden, United Kingdom

³⁵ Eurostat Asylum Statistics:

http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Asylum_statistics

³⁶ Ibid

Raghallaigh, 2013). Others involved the secondary analysis of the GUI data exploring the challenges of integration among children from ethnic minority groups in Ireland (Coughlan et al., 2014; Nolan; 2014) and reviewed existing research (Fanning, 2001; Ní Shé, 2007). Some combined elements of primary research and secondary analysis (Arnold, 2013).

It is evident that no nationally representative study has been carried out of asylum seekers in Ireland. Therefore while these results cannot claim representativeness their findings do serve to highlight the main challenges faced by asylum seekers in Ireland. The main findings of the reports are presented under the relevant headings in the model of child development.

Physical health

Many studies report poor physical environment and living conditions including overcrowding, poor heating, poor ventilation, damaged property in Direct Provision accommodation centres (Arnold 2013; Healy, 2012).

Dietary provision and the regulation of meal times represent restrictive aspects of living in DP (Healy, 2012). Parents are not allowed to cook and/or lack adequate cooking facilities to make family meals for their children (Stewart 2006; Healy, 2012, Clarke, 2006; Collins 2002; Arnold 2013). For example it was reported that residents in the Eyre Powell centre in Newbridge, Co. Kildare received “a steady stream of chicken nuggets, white rice, ketchup, vegetables and chips... a distinct lack of toddler appropriate foods... they always had chips, sometimes with sausage and beans, but always chips or ‘fast foods’” (Arnold, 2013). In addition parents have no resources through which they to supplement the diets of their children with more nutritious foods or ethnically specific diets (Arnold 2013; Clarke, 2006; NíShé, 2007). Consequently hunger among adults, malnutrition among expectant mothers, ill health due to diet among babies, and worries about health of children and weight loss among children were reported (Arnold, 2013; Healy, 2012; Fanning 2001).

The studies also highlight that there are few outdoor and indoor play and exercise facilities for children in DP centres and few opportunities for them to take part in local sports and other activities. This resulted in children spending a large proportion of their days sleeping and watching television (Arnold 2013; NíShé, 2007).

Parental health and educational status were also found to be an indicator for child health outcomes (Collins, 2002; and Clarke, 2006).

Social, emotional and behavioural health

The ability of the child to cope/develop resilience in the face of traumatic events in their lives plays an important role in their development (Arnold, 2013). The displacement and stress associated with seeking asylum are compounded by not knowing the outcome of their decision or whether they may be sent back to their home country, and/or transferred from one accommodation centre to the next at random (ibid). This

promotes an underlying sense of temporariness and compounds the potential for social exclusion affecting the children's confidence and coping mechanisms (Collins, 2002; Clarke, 2006; Arnold, 2013).

Several studies also identified depression through the anxiety of deportation, and boredom with many respondents stating that they did not have anything to do to keep them occupied during the day (Collins, 2002; Clarke, 2006; Stewart, 2006; Beirens et al., 2007; and NíShé, 2007). Many asylum seekers reported that they did not have any Irish friends or acquaintances and few opportunities to meet Irish people (Stewart 2006). This isolation and discrimination may have negative effects on children mental health.

Parent's ability to care for their children was found to be impaired due to poverty, poor accommodation, and other factors as a result of living in DP (Arnold, 2013). There were significant correlations found between parent and child mental wellbeing (Stewart, 2006; Arnold, 2013). Over a period of time asylum seekers experience the 'construction of dependence', institutionalisation, and infantilisation which results in insecurity and powerlessness (Arnold, 2013; Fanning, 2001; Clarke, 2006). Removing the opportunity to make decisions was reported to affect parental health which can have secondary effects on child mental health and led to 'parentification' in some cases (Stewart, 2006).

Overcrowding, a lack of privacy in DP centres, entire families living in one room with teenagers of both sexes, and a lack of adequate facilities were reported (Arnold, 2013). Within DP competition over scarce resources was also common leading to cases of theft, violence, and abuse (Arnold 2013; Vanderhurst 2007).

Those who live in DP centres which are not located near an urban centre have limited access to local shops, community centres and amenities (Arnold, 2013). This isolation was compounded by the rule of DP centres which do not allow visitors in the children rooms making it harder for children to make Irish friends outside schools (Arnold, 2013; Ní Shé, 2007). Children reported feeling lonely because they could not play outside when the weather was poor nor invite friends to their room (Arnold, 2013; Healy, 2012, NíShé, 2007). In addition tensions between asylum seekers in DP centres who came from different cultural, religious and ethnic backgrounds was reported (Vanderhurst, 2007; Beirens et al. 2007).

Finally it was reported that victimisation, discrimination and bullying were found which result in anxiety and stress (Clarke, 2006; Stewart, 2006; Arnold, 2013).

These studies highlight asylees experiences of feelings of isolation, prejudice, vulnerability to harassment and victimisation, and discrimination through which cultural barriers emerge compounding the effects of existing trauma and stress, anxiety and depression (Stewart, 2006; Arnold, 2013; Clarke, 2006).

Educational and cognitive capacity

The school environment was reported to be the primary place where children socialised and felt that they participated in Irish society (Arnold, 2013). Children's networks, however, are limited as a result of extreme poverty meaning children cannot afford to participate in extracurricular activities, especially those that are structured such as homework clubs, sports and cultural activities (learning an instrument, ballet, other artistic endeavours) and those that are unstructured (socialising with peers, unorganised sporting activities, birthday parties etc.) (Arnold, 2013; Coughlan, 2014). A lack of participation in structured activities by minority groups is a clear indicator of social exclusion (Arnold, 2013; Coughlan, 2014; Fanning, 2001). It was also shown that children who participate in structured activities tend to improve language and literacy, and communications skills (Coughlin, 2014). Many children living in asylum systems were also found to be in need of extra English language classes which are not provided in all schools (Clarke, 2006; Coughlan, 2014). The inability to take full advantage of the education and school experience hampers them in pursuing their potential (Arnold 2013). In addition some schools do not account for educational disruption, trauma, and stressful living conditions (Clarke, 2006). In addition to pre-existing trauma, in some cases children were moved from one centre to others in different locations removing them from their friendship networks and schools causing undue stress (Doras Luimní, 2011).

Finally limited access to computers and other educational materials (Arnold, 2013; Clarke, 2006) and inadequate quiet study facilities in DP centres further impact on the child's educational potential (Arnold, 2013; Fanning, 2001). Finally various reports suggested that access to preschool facilities were limited (Fanning, 2001; Arnold, 2013; Healy, 2012).

3.2. International Studies

14 international studies were examined including research from the Netherlands, the UK, Australia, Finland, and the US. 1 examined primary quantitative data (Wiergsma et al., 2011³⁷); 1 primary qualitative data (Ingleby and Watters, 2005³⁸); 3 used both (Sourander, 1998³⁹; Wiese and Burhorst, 2007; Kalverboer et al., 2009⁴⁰); 7 analysed secondary qualitative data (Cemlyn & Briskman, 2003⁴¹; Bhabha, 2001 and 2004⁴²; Tuk, 2005⁴³; Christie & Sidhu, 2006⁴⁴; Athwal and Bourne, 2007; Beirens et al., 2007⁴⁵);

³⁷ Wiergsma, Stellinga-Boelen, and Reijneveld (2011) employed the multi-informant Strength and Difficulties Questionnaire to explore whether children of asylum seekers residing in The Netherlands

³⁸ Ingleby and Watters (2005) compare the mental health and social care of refugees across Europe using qualitative from four countries: the United Kingdom, The Netherlands, Spain, and Portugal.

³⁹ Quantitative study in study captured primary quantitative data from 46 unaccompanied asylum seeking children in Finland Australia

⁴⁰ Kalverboer, Zijlstra, and Knorth's (2009) study examines the European legal framework and the established policy regulations which govern asylum systems.

⁴¹ Existing qualitative data from a study of Australian asylum centres.

⁴² Conducted secondary analysis of qualitative data in the US

⁴³ Qualitative research study in The Netherlands

and 2 examined secondary quantitative and qualitative data (Fazel & Stein, 2002⁴⁶; Barowsky & McIntyre, 2010⁴⁷).

Physical health

The studies reported that the key issues which impacted upon health included poor accommodation families living in one room and often having to move as centres closed down (Tuk, 2005). In some cases children were suffering from anaemia, parasitic infections, and dental issues, along with 43% being positive for hepatitis B surface antigen and 20% were latently infected with the tuberculosis bacterium (Bhabha, 2001 and 2004). In other studies asylum support organisations reported that the majority of their residents experiencing hunger and could not afford to supplement their children's diets (Penrose, 2002⁴⁸; Cemlyn and Briskman 2003).

Social, emotional and behavioural health

Some studies showed that children suffered from psychosocial problems from both their flight and their stay within the residential centres (Wiergsma, et al, 2011; Fazel and Stein, 2002). These studies highlight that many of these children suffered primary trauma through exposure to war, murder, sexual assault, and other forms of violence. Anxiety disorders, depressive disorder, stress, sleeping problems, and behavioural difficulties manifesting in physical symptoms (Sourander's, 1998; Tuk, 2005; Fazel and Stein, 2002; Wiese and Burhorst, 2007) including self-harm and suicidal ideation (Barowsky and McIntyre, 2010) were also reported. Children also reported being ashamed of their position (Tuk, 2005). Inadequate mental health supports were provided (Tuk, 2005).

A shortage of education, training, monitoring, and boredom plays a significant part in their experience (Ingleby and Watters, 2005).

Educational attainment and cognitive capacity

An Australian study found that there was a lack of educational opportunities for children while living asylum or detention centres (Christie and Sidhu's, 2006). Children in asylum institutions were provided with approximately 4 hours of education per week and had a teacher to student ratio of 1:300 and frequent turn-over in staff (ibid). They reported that personal relationships were discouraged with children being referred to as numbers rather than their names (ibid).

⁴⁴ Christie and Sidhu's (2006) paper concentrates on the lack of educational opportunities for children while living in Australian asylum or even detention centres.

⁴⁵ Beirens, Hughes, Hek and Spicer (2007) examined existing qualitative research completed by the UK National Evaluation of the Children's Fund which employed Ager and Strang's *Indicators of Integration Framework* (2004).

⁴⁶ Examined secondary qualitative and quantitative data in their study exploring children's mental wellbeing during the three stages of migration (pre-flight, flight, and re-settlement)

⁴⁷ Barowsky and McIntyre (2010) interpret the findings from a number of qualitative data sources in New South Wales, Australia, examining the socio-emotional factors that asylum seekers experience when they are forced to migrate.

⁴⁸ Australian asylum accommodation system in 2002.

4. Models of child development in the context of migration: current models and frameworks for studying children and migrants

The objective of this paper is to produce a framework to facilitate the examination and measurement of the development and wellbeing of children growing up in asylum systems and apply that framework using Ireland as a case study.

The biopsychosocial model of child development adopts the whole child perspective built upon Bronfenbrenner's (1979) *bioecological model of child development*⁴⁹ and is used in the nationally representative study of children in Ireland, *Growing Up in Ireland (GUI)*. The Bronfenbrenner model relates to the case of children growing up in typical situations and does not adequately cater for atypical developmental environments. While GUI includes measures of the numbers of children from ethnic groups among the child population it does not go so far as to specifically target or identify children growing up in asylum systems. This paper augments the Bronfenbrenner model integrating it with the Ager and Strang *Indicators of Integration Framework* (2004) which identifies issues which relate to migrant children. Finally the review of national and international literature and research examining the living conditions of asylum seekers and their children allows for the tailoring of this model to identify the unique set of challenges this subgroup of ethnic minorities face.

4.1. Bronfenbrenner's ecological model of child development (1979)

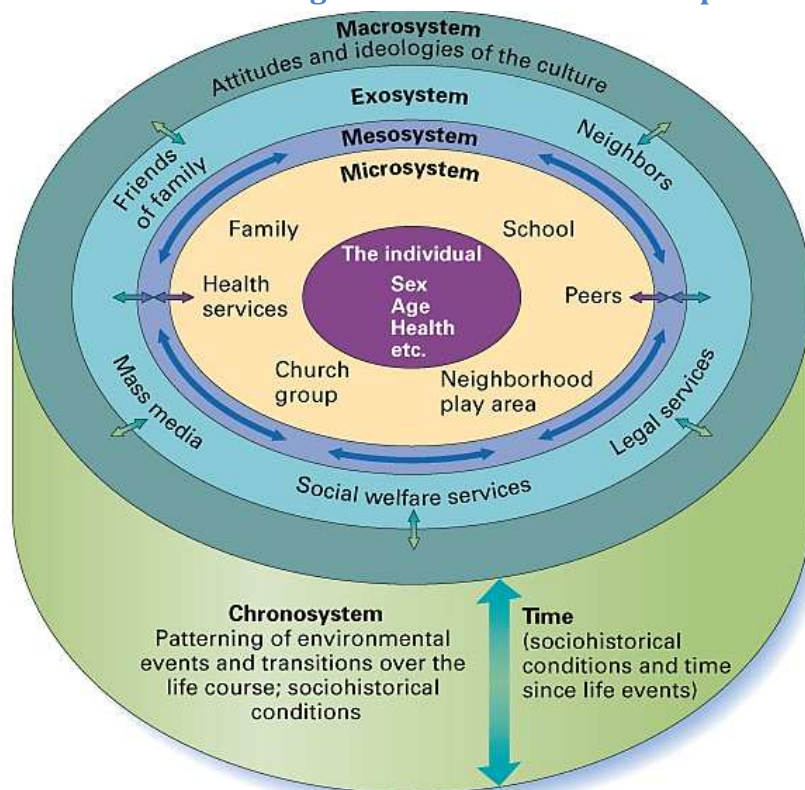


Figure 1: Graphic depiction of Bronfenbrenner model (1979)⁵⁰

⁴⁹ <http://www.growingupinaustralia.gov.au/index.html>

⁵⁰ <http://cicsworld.centerforics.org/wp-content/uploads/2011/11/02061.jpeg>

Bronfenbrenner's (1979) ecological model of human development involves multi-layered and interconnecting environmental systems defined as four inter-related activity zones which contribute to developmental outcomes of the child.

The individual child is located at the centre of the model. The four key systems include the microsystem which consists of the face to face interactions that the child experiences. The mesosystem is where social connections are created between the different actors in the microsystem and official state institutions. The exosystem is made up of the structures and institutions of a society, including the working life, banking, local politics, legal systems, social services, and local community organisations. Finally the macrosystem is where culture, ideology, attitudes and beliefs that shape societal structures and practices are located. All the levels are interrelated and socially constructed through horizontal (intrasystemic) and vertical (intersystemic) communication. This allows for the existence of agency and systems of control.

Measurable indicators of child development are identifiable on the individual and micro level. It also identifies the role that all the other systems play in supporting this development. Some indicators are positive or protective, and some are negative or risk inducing. Current research emphasises a movement away from risk factors towards identifying protective factors which enable children maximise their potential, and determining the ways in which these can be supported. Processes that contribute to negative developmental outcomes will be compounded by existing disadvantages such as poverty, dysfunctional family life etc. While a focus on the protective factors is progressive.

The model defines processes, the person, the context and the time of an event/duration of a process as the four defining properties through which development emerges. First, the proximal process refers to the development of the human being over time; second, the person is characterised by their disposition, biopsychosocial resources, and demands on them which invite or discourage growth; third, the context recognises that the person is developing in a specific environment constituted by social, cultural and historic settings; and fourth the model suggests that events occur linearly through time in the life path of an individual.

The Growing up in Ireland study⁵¹ identifies five 'parallel insights' as part of the conceptual framework by which to examine the influence of the indicators on the developmental opportunities of the child across multiple levels simultaneously. First, ecology (bioecology) refers to the influence of proximal and distal influences on the child and integration of the different layers of environmental systems. Child development outcomes are not only influenced by immediate surroundings e.g. family, school, home, but also influenced by events in the wider community and society e.g.

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http://www.growingup.ie/fileadmin/user_upload/documents/Technical_Reports/Review_of_the_Literature_Pertaining_to_the_First_Wave_of_Data_Collection_with_the_Child_Cohort_at_9_Years_01.pdf

impact of the national economy on the Direct Provision system and ideological disposition towards migrant population. Secondly, dynamic connectedness emphasises that changes on one level may affect all other levels. Thirdly probabilism recognises that the interrelationship between variables on different levels changes over time. Individual life courses can consist of multiple paths dependent on the individual's social background, resources and the historical period in which they live etc. The fourth is the period effect that recognises that events occur not only at specific junctures in the life path of the individual but in specific socio-historical contexts which influence the acceptance of migrants by the majority population. The fifth insight recognises the active role of the child through their reflective cognisance, their circumstances and the active role of agency.

The case of children growing up in asylum institutions raises a specific challenge to this model by impeding the child's access to their full fundamental rights, isolating them from the majority population, and hence diminishing their capacity for autonomous action. Ager and Strang's (2004) framework presents a partial solution to this challenge.

4.2. Ager and Strang *Indicators of Integration Framework* (2004)

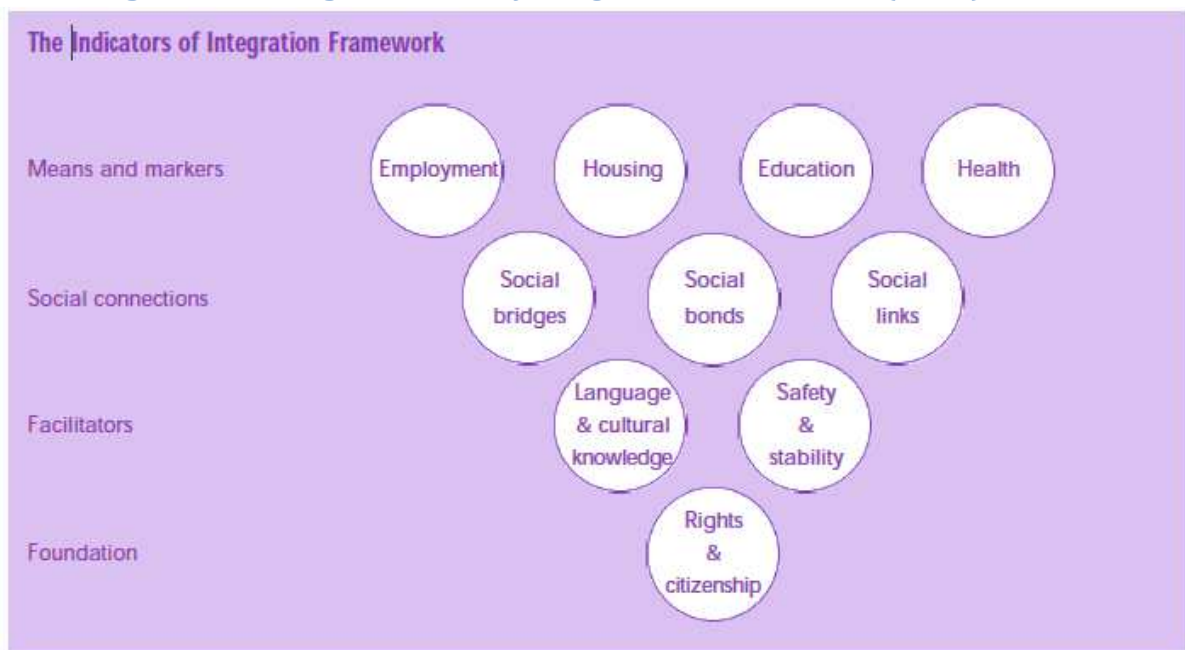


Figure 2: Ager and Strang, *Indicators of Integration Model* (2004)

This framework presents a model by which the challenges to integration by migrants into a society can be measured. The framework they propose is based on ten domains which contain indicators for integration. This framework is flexible and may be applied in different formats to specific case studies.

Means and markers (employment, housing, education and health) represent key domains of public activity upon which value is placed. The attainment of these markers is a means for integration into the host community.

Social connections involve the different one-to-one relationships and networks that support integration among individuals. *Social bonds* refer to connections with others of the same ethnic community, or who are thrust together through circumstance. These connections may include those who share the same experiences and values through ethnicity, religion, country of origin, or collective experiences. Connections with other communities are termed *social bridges*. Finally, *social links* refer to those connections that enable individuals to access state services and institutions.

Foundation refers to the normative principles which define what is expected from the state and from other members of communities and what is expected of the migrant. These are principles grounded in fundamental human rights and the expectations and obligations of citizenship (Ager and Strang, 2004: 15).

Finally facilitators refer to the key skills, knowledge and circumstances that help migrants to actively participate with host communities. They are measurable as outcomes of child development. They refer to the provision of education, health facilities, safety and stability in the life of the child within which they have the opportunities to maximise their potential.

Aspects of this model may supplement or augment the generic conditions set out in Bronfenbrenner above and more accurately advance an aggregate model by which the unique developmental challenges faced by children growing up in asylum can be examined.

5. A model of childhood development for children growing up in Direct Provision centres

5.1. Conceptual model

Merging these two approaches builds a model which includes measures of child development and wellbeing and indicators of integration. The literature review provides empirical evidence of the validity of such a model, identifies the specific challenges faced by children growing up in asylum systems which are in addition to those faced by migrant children, and illustrates its potential uses by identifying the specific indicators of development for this population. This is a Biopsychosocial model of child development for children growing up in asylum systems.

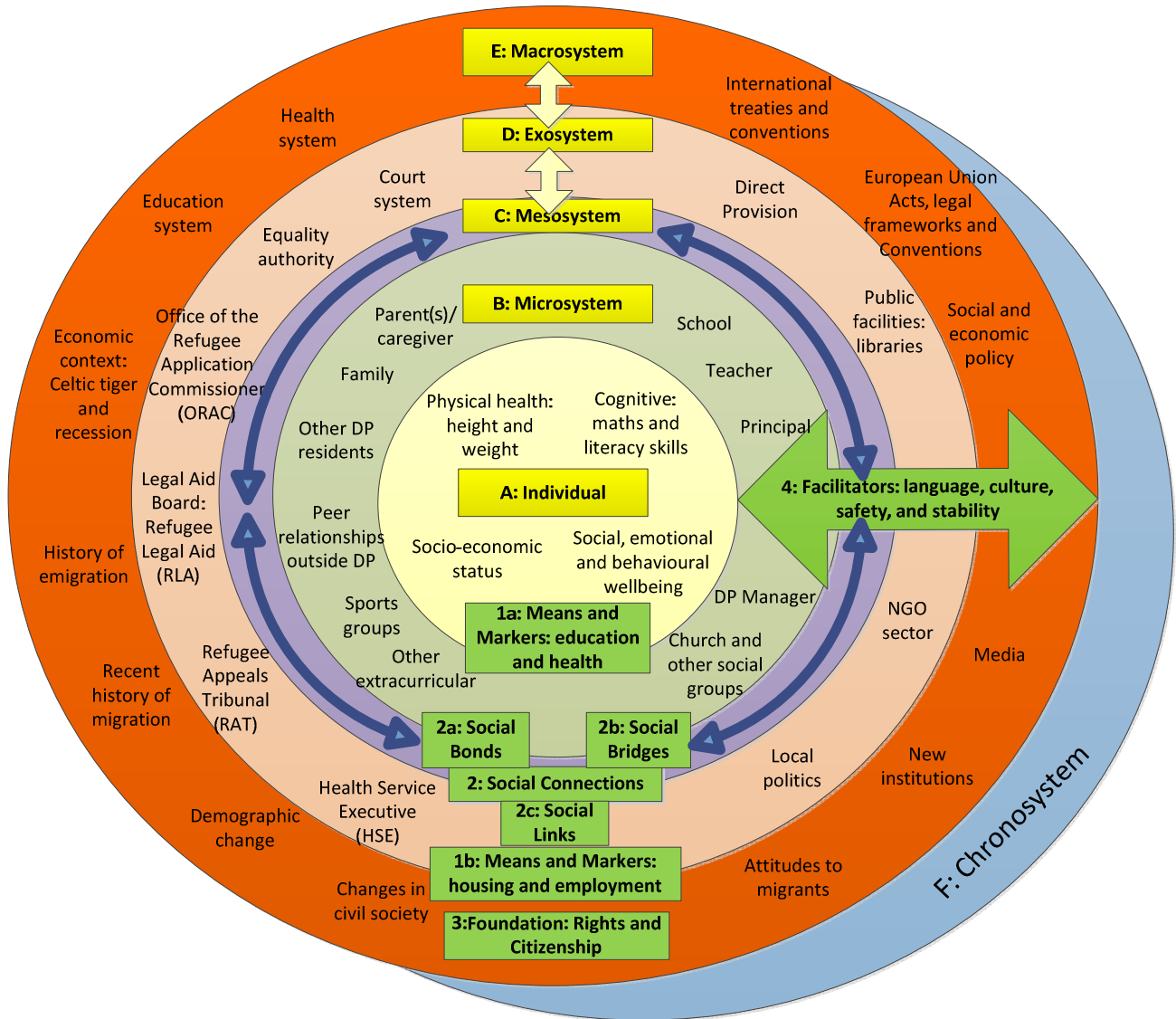


Figure 3: Biopsychosocial model of child development for children growing up in asylum systems

The biopsychosocial model suggested here represents an adaptation of Bronfenbrenner’s model, includes elements of Ager and Strang’s framework, and evidence from the case studies.

In this instance the indicators of child development for children growing up in asylum institutions are identified at the (A) individual level and are cognitive skills, physical health, child’s disposition/emotional wellbeing and take account of the ecology of the proximal and distal influences on the child and the active role of the child.

The manifestations of these individual characteristics are identified at the (B) micro level and include social and behavioural wellbeing. The relevant (1a) means and markers of social integration are education and health. These can be understood as the proximal processes.

(2a) Social bonds and (2b) social bridges are determinants of the capacity for members of ethnic minority groups to integrate with a majority population. They are measurable through indicators of social, emotional and behavioural wellbeing of the child through the indicators identified above at the (A) individual level and through their integration and involvement in peer networks and extracurricular activities at the (B) micro level.

At the (D) exosystem level, which describes the connectivity between the (B) micro and (C) meso levels, (2c) social links define where interaction between official state institutions and mechanisms and asylum seekers are measurable. Connectedness suggests that all these levels are interrelated and changes on one level effects all other levels. The period effect suggests that these changes happen at specific junctures in the life path of the individual and in a specific socio-historical context.

The literature review presented suggests societal level indicators which influence the health and wellbeing of children growing up in residential centres for asylum seekers. Specifically, at the (E) macro level, meta-narratives involving complex and often contradictory framing and reframing (Strydom, 2000) of the situation of asylum seekers emerge through the public debate. For example, media⁵² and political narratives (including public policy discussions and party positions) simultaneously provide and inform the public who do not have direct evidence of the circumstances under which asylum seekers live in Ireland. They are, in some cases, framed from a certain point of view which is not always unbiased. These re-presentations of 'fact' influence the form of the societal level discourses around asylum seekers which are set within current Irish social, economic, cultural, historical and political contexts. These narratives influence the: a) (3) foundation upon which the legal situation of asylum seekers are debated and how their fundamental human rights (citizenship) are upheld; and b) the form which societal institutions may take at the (D) exosystem level.

Finally, this model allows for the identification of risk indicators and the promotion of protective factors which positively influence child development. It is (4) facilitators such as language skills and awareness of the culture of the host community and country, and provision of the means to live in a safe and stable environment, that promotes integration. These facilitators act as protective measures in the development of the child which may promote social and emotional stability. This outcome is measurable as behavioural skills in their interactions with friends, family and their wider community. It enables them to engage more effectively with the institutes of the state. Ultimately these facilitators support increased access to information, wider awareness of their human rights, and the promotion of integration within host communities.

5.2. Employing the model in research

The following outlines the variable which are to be measured in a research design exploring the health and wellbeing of children growing up in asylum systems.

⁵² See 5.3.2 for a further example.

Physical health

This model suggests that physical health measures for children include age, height and weight as well as diet, eating habits, nutrition and child's activity. This information is supplemented by descriptions of the child's physical and mental wellbeing by the child, parent and their teacher. Their health at birth gives some indication as to issues that they may have faced from a young age. Long terms illness and medical conditions are also significant indicators of physical health. Physical safety and the infrastructure and lack of hazards in the home and wider environment are also important contributors. The variables are presented below as they relate to the specific case studies.

Variables	Children living in DP
<ul style="list-style-type: none">• Diet	<ul style="list-style-type: none">• Provision of food at centre• Access to supplementary food• Flexibility of meal times• Resources available to parents to supplement diet
<ul style="list-style-type: none">• Exercise	<ul style="list-style-type: none">• Leisure and sports facilities available at the centre• Distance to urban centre• Physical education at school• Capacity for child to take part in structured and unstructured extracurricular activities
<ul style="list-style-type: none">• Accommodation	<ul style="list-style-type: none">• Quality of DP accommodation and suitability for children
<ul style="list-style-type: none">• Illness or disability	<ul style="list-style-type: none">• Existing disability• Access to medical and psychiatric treatment
<ul style="list-style-type: none">• Parents capacity to care for their child	<ul style="list-style-type: none">• Access to health and social care

Figure 4: Factors influencing outcomes among Children growing up in DP

The role of the parent in supporting the child's development relates to their ability to care for the child's health and physical wellbeing. These include the provision of sufficiently nutritious diet, monitoring of the child's physical health, and their level of physical activity. Responsibility also extends to the provision of a safe place to live and ability to keep them safe from physical harm/accidents, ensuring that they maintain basic hygiene standards, warmth, clothing, and some personal belongings. The parent's opinion of the child's current health also indicates their approach to the maintenance of their child's physical health and history of illness.

The parent also acts as the main liaison between the child and the health services including dental care, vision, speech, hearing, and mobility. The ability to support and nourish the child's development is effected by the parent's physical health, height and weight. Ongoing illness and its effect on the ability to parent the child, whether this results in someone else have to take care of the child.

Social, emotional & behavioural skills (including pro-social behaviour, mental health, behaviour)

The key indicators of social, emotional and behavioural skills are a child’s disposition, a child’s mental health, and their behaviour. It is argued that growing up in DP has significant influence on these. The following tables identify the key variables which measure the social, emotional and behavioural skills of children growing up in the asylum system.

Variables	Children living in DP
<ul style="list-style-type: none"> • Childs disposition 	<ul style="list-style-type: none"> • Self-perception as an asylum seeker • Ethnicity • Lack of autonomy

Figure 5: Childs disposition and self-perception for children living in DP

Variables	Children living in DP
<ul style="list-style-type: none"> • Experience of trauma 	<ul style="list-style-type: none"> • Trauma in country of origin • Trauma during the asylum process • Access to mental health care facilities
<ul style="list-style-type: none"> • Parents mental health and capacity to care for their child 	<ul style="list-style-type: none"> • Trauma in country of origin • Trauma during the asylum process • Limited access to metal health facilities • Awareness of child’s mental health • Marital status and family composition: number of family members in Ireland and/or asylum, contact with wider family network • Access to resources and capacity to engage in family activities
<ul style="list-style-type: none"> • Stress/anxiety 	<ul style="list-style-type: none"> • Length of time resident in DP Bullied, harassed, victimised as an asylum seeker • Exposure to intercultural rivalries in DP centre Level of isolation due to lack of resources and location/lack of transport • Experience of secondary trauma via parent

Figure 6: Childs mental health for children living in DP

Variables	Children living in DP
<ul style="list-style-type: none"> School 	<ul style="list-style-type: none"> Ethos of the school and classroom (e.g. anti-bullying) and provisions which specifically support children growing up in DP addressing issues such as ethnicity, status as asylum seeker, and severe lack of resources and capacity to engage in extracurricular activities Environment of the school which supports children growing up in DP to make meaningful relationships with peer groups
<ul style="list-style-type: none"> Accommodation 	<ul style="list-style-type: none"> Capacity to engage in social activities at the centre/facilities Provision of stimulating environment in DP Ability to bring non-DP peers to centre Location of the centre, vicinity to urban centre and transport available Safety and stability, and risks, at DP
<ul style="list-style-type: none"> Neighbourhood 	<ul style="list-style-type: none"> Rural/urban Demographics of the area Frequency of racism, bullying, harassment Local activities/facilities

Figure 7: Childs social behaviour for children living in DP

Children need autonomy and a sense of purpose (Bernard, 1991). Children need stability in their circumstances allowing for a future perspective and to be a socially connected member of a community are outcomes of positive child development (Age and Strang, 2004: 5). Poor early peer integration may lead to poor sociality in adulthood. Stable peer networks and access to resources allow them to develop and maintain normal contact with peer groups supported by normal external resources. This reduces anxiety and increases sociality and the potential for peer integration and has the potential to reduce delinquency (ibid).

In summary children growing up in asylum need access to services in areas such as accommodation, food, legal needs, education, social support, health and welfare, and social freedom and facilities to express their culture and heritage. In addition in many centres children are not allowed to have visitors in their rooms to play as it against house rules of the DP centres (Ní Shé 2007; Arnold 2013). These present significant barriers to integration and development.

Educational achievement and intellectual capacity

A child's intellectual development is measurable by their cognitive skills and linguistic skills. There are, again, issues that unique to the case of children growing up in the asylum system.

Variables	Children living in DP
<ul style="list-style-type: none"> • Maths scores • Reading and language skills 	<ul style="list-style-type: none"> • Children’s education prior to arriving in Ireland
<ul style="list-style-type: none"> • School 	<ul style="list-style-type: none"> • School ethos and facilitation of children who may need special assistance (e.g. poor language and/or maths skills) • Teacher – child relationship and specific resources provided to the teacher to support children with specific needs
<ul style="list-style-type: none"> • Accommodation 	<ul style="list-style-type: none"> • Pre-school activities • Study facilities in DP • Educational support services available at DP centre • Resources: computers, books, etc. • Vicinity to urban centre and facilities: e.g. library
<ul style="list-style-type: none"> • Extracurricular activities 	<ul style="list-style-type: none"> • Availability of free homework groups • English language supports
<ul style="list-style-type: none"> • Family 	<ul style="list-style-type: none"> • Parents education: level of English and maths • Time spent assisting children with homework • Awareness of child abilities and requirements of curriculum • Parent-teacher relationship

Figure 8: Educational achievement and intellectual capacity for children living in DP

5.3. Situating the data and inferences in the wider model

5.3.1. Social connections

Within the Ager and Strang framework (2004) we can distinguish between means and markers that directly measure children’s integration (education and health), and those that operate through the parents (employment and housing). These are critical indicators of integration, independence, self-sufficiency and identity for the parents of these children. As highlighted earlier asylum seekers are not allowed to work and their housing circumstances are dictated by the conditions of DP. Therefore employment and housing are only relevant in that they are significant means and markers which are not available to asylum seekers.

As adult asylum seekers cannot work, attend full time education, seek independent housing, have few resources, and cannot engage in traditional parenting roles such as preparing meals, their capacity to create social connections and act as a role model for their children is reduced. This can have a negative effect on their mental wellbeing and consequently the wellbeing of their child (Arnold, 2013). In some cases the children

may have access to more social interactions with the host community than their parents. We may ask is it the child who emerges as the main interlocutor between the family and the host community through their participation in school? Do poor housing, the inability to seek employment, and the incapacity to carry out parenting roles lead to the infantilisation of the parents? Does this have a direct effect on the wellbeing and development of children growing up in DP? Does it have an indirect effect through the parents? If so, is that because the parents are in poor mental health, or because the system infantilises the parents? To examine this we must measure the mental wellbeing of the parents enabling us to identify what parentification looks like and how we can measure it and what is the frequency by which this occurs in parents bringing up children in DP? We must also then measure what impact this may have on their children? Does this in turn lead to the parentification of the children?

The prevalence and influence of these issues can be measured through capturing data about the child and parent mental wellbeing and their roles in the family, their accommodation and other key indicators identified above. What can also be examined are in which ways these challenges can be minimised through the establishment of effective social connections for parents and children with the host community.

Social bonds

Social bonds are possible at the micro level. In the case of these children their main social bonds emerge between them and other children living in DP with them. The commonalities they share may include living and growing up in similar circumstances of isolation and poverty, and religion. These bonds are crucial to the provision of a sense of identity and can provide connections to others through religious and cultural groups. While these bonds support the child's development through supportive peer networks, this may be an over simplistic view.

First, asylum seekers are not a homogenous group and they come from many different countries with different cultures, religions, beliefs and social norms. Therefore social bonds between asylum seekers are not as simple as between those of the same nationality, ethnic and religious background who have access to more resources and may form collectives more easily as in the cases of other migrant communities. Second, in some cases, strong social bonds may reduce the opportunities for the child to make friends outside DP. This can reinforce isolation, segregation and institutionalisation. This may increase the possibility of discrimination and victimisation. Finally, as children may be moved from one DP centre to another, the social bonds established within DP are fraught with a sense of temporariness.

Social bridges

The main areas where children make social bridges are within school and through participation in community or social activities where this is possible. One issue which reduces the capacity of children to form social bridges is their inability to take part in extracurricular activities, whether structured or unstructured. In some cases this is due

to the isolated location of DP centres and a lack of transport, and in others it is due to a lack of resources (financial and equipment) by which they may take part in activities. A lack of access to social media, as a result of a lack of access to a computers or mobile technology in the DP centres, also reduces children's opportunities to form and participate in external peer networks through online communities.

Parent's main social bridges with which the children are involved are formed largely through church groups, free education programmes, with other parents through school and community groups, and through community support groups (Arnold, 2013). They are restricted in many cases as they have few economic resources, lack access to transport, and are restricted via strict meal times in DP. Barriers to participation have the effect of weakening social bridges with the wider community and minimise their potential to integrate.

Social links

The main social links for children are at the meso level through school, medical health support, and possibly through a children's church group. Social links are mainly facilitated through the children's parents. Links include communication with local services, schools, NGO's, other civic groups, health care, child care, local political representatives, legal aid, the court system, asylum and refugee services, and the Equality Authority.

Institutional living and a lack of employment remove the opportunities for adult asylum seekers to construct links common to members of the host community including employers, employment organisations, and banks as they relate to employment, and landlords, residents associations, and neighbourhood committees as they relate to housing. This limits the capacity of the parent be a role model for their children.

Social connections: summarising the facilitators and supporting developmental outcomes for children growing up in DP

Children have direct access to health care services, and their parents have direct access to health care, social services, DP staff and managers, NGO groups, the court services, and the education services provided for their children. All may serve to connect an individual or group with the wider host community (Ager and Strang, 2004: 15)

Cumulatively, social connections represent critical facilitators of social integration for children and their parents. Ager and Strang (2004) note that, for refugee children living in asylum institutions, school is an important place of contact with the host society, and that experience depends upon **facilitators** such as the English language skills, familiarity with school system and social norms, and feelings of safety and stability in their living circumstance.

5.3.2. Macro level indicators: culture, ideology, and policy

While the Refugee Act 1996 is the principal legislation governing applications for asylum in Ireland, there remains no legislative basis for the system of direct provision in Ireland (Joyce & Quinn, 2014; Thornton, 2013). Asylees are protected against criminal acts, have the right to accommodation, basic financial support, and food, and children under 18 have the right to full time education. They are, however, not entitled to work, to basic social welfare allowances, or the freedom of movement outside the state. For most citizens, and for the children of asylum seekers, their rights derive from their parents. However in some cases parental right to reside in a country can derive from the children's rights – particularly in the case of Irish-born children to non-EEA citizens. This can have important implications of parent - child relationships. This reduces the child capacity to access resources and the parent's opportunities to provide them. Thornton (2013) argues that children living in asylum institutions in Ireland are unique in that they have no statutory or constitutional rights. Thornton argues that there “is a strong argument, that the approach taken by various government ministries and state administrative agencies in establishing the system of direct provision from April 2000 to present day, is not only administratively deficient, but questionable as to its legality” (Thornton, 2013: 37).

In addition to the withholding of fundamental rights, the media have in the past, distorted the public perception of asylum seekers claiming that they are in receipt of ‘extravagant benefits’, and their being classed as criminals (Thornton, 2013: 92). This has been redressed somewhat by recent Irish Times articles⁵³ and in a recent TV3 documentary “The Asylum Seeker Scandal”⁵⁴ exposing seriously poor conditions in which asylum seekers live in Ireland. A general population opinion poll however suggests that the majority of Irish people believe that asylum seekers should remain in DP⁵⁵.

The macro level is where societal level issues and ideological debates indirectly influence the developmental and wellbeing of asylum seekers are identified. These may include socio-economic factors (such as the general health of the economy); socio-legal factors (including changes in Europe policies); socio-cultural/historical trends (disposition towards immigrants, religion, history of immigration); and socio-political factors (including the number and remit of NGO groups actively working on behalf of asylum seekers and children).

⁵³ For example: State fears reform of system will attract asylum seekers: <http://www.irishtimes.com/news/social-affairs/state-fears-reform-of-system-will-attract-asylum-seekers-1.1575210> ; Inspections reveal poor standards in asylum centres:

<http://www.irishtimes.com/news/social-affairs/inspections-reveal-poor-standards-in-asylum-centres-1.1553372>

⁵⁴ <http://www.tv3.ie/3player/show/686/0/0/The-Irish-Asylum-Seeker-Scandal>

⁵⁵ <http://www.irishtimes.com/news/politics/majority-are-in-favour-of-direct-provision-poll-finds-1.1959839>

The factors that may influence childhood development identifiable at the macro level include facilitators (Ager and Strang, 2004) such as: creating awareness of the situation of asylum seekers in Irish society; positive reporting of asylum issues in the media; political measures to minimise victimisation, discrimination and vulnerability of minorities (and asylum seekers in particular); and proactive campaigns supporting a cultural of acceptance of migrants and asylum seekers⁵⁶. These measures should be based on solid foundations (ibid) supported by the ratification of international and European conventions and treaties such CEAS.

6. Conclusion: a biopsychosocial model of Bronfenbrenner's ecological model of human development for identifying positive outcomes for children growing up in asylum institutions

This paper set out to sketch a biopsychosocial model of Bronfenbrenner's ecological model of human development identifying critical issues and societal challenges relating to the unique case of children growing up in asylum systems, using Ireland as its primary case study. This biopsychosocial model situates child development, and their health and wellbeing, at the centre of a human rights debate which challenges the socio-legal setting, the implementation of public policy, and the institutional setting in which these children grow up, and by inference the societal perception of these individuals possessing inalienable fundamental rights. It challenges national citizens to be cognisant of this situation and the promotion of a collective responsibility to uphold the rights of this vulnerable population.

⁵⁶ <http://www.integrationcentre.ie/getattachment/eda7574b-b459-4045-be11-123b74bcd0d/Annual-Monitoring-Report-on-Integration-2012.aspx>

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