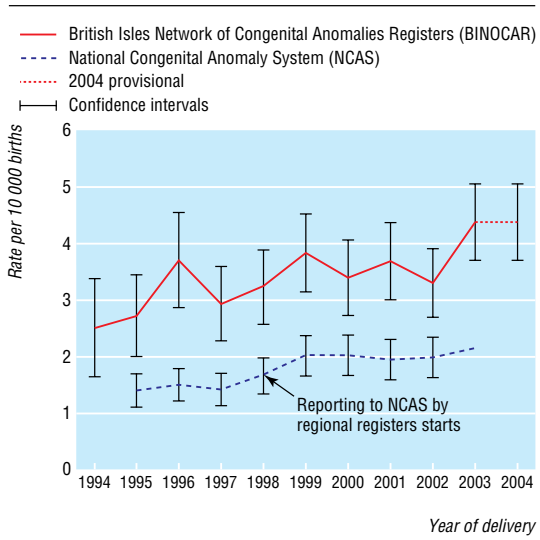

Number of reported cases of gastroschisis between 1994 and 2004. Reproduced with permission from the Department of Health

different register types has been well described.[7] The UK's chief medical officer has expressed concern about the rising incidence of gastroschisis (L Donaldson, personal communication, July 2005) and has highlighted the importance to public health of rigorously compiled and centrally funded regional registers in providing information on congenital anomalies.[8]

Recent data from the British Isles Network of Congenital Anomaly Registers (BINOCAR) confirm the increasing incidence of gastroschisis—from 2.5 per 10 000 total births in 1994 to 4.4 per 10 000 in 2004.[8 9] Among babies of women aged under 20 the incidence of gastroschisis increased from 8.9 to 24.4 per 10 000 total births. In addition, the incidence in some registers is four times as high as in others across different regional registers—for example, the Welsh register indicates an incidence of gastroschisis of 6.2 per 10 000 total births, whereas the rate in North West Thames was 1.6 per 10 000.

The observed increasing incidence of gastroschisis over time seems to be associated consistently with lower maternal age.[2] Gastroschisis probably does not have a genetic cause because it occurs sporadically, with a relatively low recurrence rate. The most likely cause is early interruption of the fetal omphalomesenteric arterial blood supply. This may be associated with periconceptional tobacco smoking and use of recreational drugs such as alcohol, marijuana, and cocaine.[10 11] The evidence for these associations is, however, only tentative and needs confirmation by carefully controlled cohort or case-control studies.[12 13] Along with data from regional registers, such studies may lead the way to understanding the pathogenesis of this distressing condition and thus preventing it.

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Detention of refugees

Australia has given up mandatory detention because it damages detainees' mental health

More than 7 million of the world's 17 million refugees remain "warehoused" under conditions of confinement,[1] raising serious human rights issues about the treatment of people fleeing oppression. The British policy of expanding detention centres for asylum seekers adds to this concern, making it timely to consider what lessons might be learnt from Australia's recent reversal of its mandatory detention policy.

In 2002 Australia stood alone in introducing indefinite, non-reviewable, mandatory detention for asylum seekers arriving by boat or without valid entry documents. Asylum seekers of all ages, including children, were held for years in remote detention centres. From the outset, the medical profession (clinicians, researchers, the Australian Medical Association, and specialist colleges) raised concerns that detention might adversely affect the mental health of traumatised refugees.[2] Clinical observations were supported by research conducted by an Iraqi doctor held in detention[3] and by Australian specialists in refugee mental health.[2 4] A recent study found that confined children and their parents suffered from a range of mental disorders largely attributable to detention.[5] The

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social consequences observed in centres include high rates of suicide (completed and attempted), interpersonal violence, riots, burning of facilities, hunger strikes, and acts of public self mutilation.

The situation in Australia reached crisis point this year. Cases came to light of mentally ill Australian citizens being apprehended and erroneously deported or held in detention centres without adequate psychiatric care. The recent Palmer inquiry into one of these cases was critical of both the culture of detention centres and the procedures involved, highlighting the lack of scrutiny and accountability in detention centres and inadequacies in mental health care.[6] In June Australia's Prime Minister admitted that the detention policy had failed, and the government subsequently changed the law[7] and released all confined children and their families. Administrative provisions have been amended, abolishing mandatory detention and allowing those asylum seekers who are detained to challenge their confinement.

Yet Britain increasingly seems to be pursuing Australia's failed policy of detention. About 25 000 people have been held in 10 removal centres in the past year,[8] and the latest immigration bill seeks to expand detention facilities and the capacity to effect forced removals.[9] Four centres hold children, placing their normal psychosocial development at risk by exposing them to isolated, deprived, and confined conditions, a situation that bodes poorly for their future adaptation, whether they are ultimately resettled or repatriated.[10]

Medical observations in Britain concur with those from Australia, with attending doctors noting that detainees, particularly those held for long periods, suffer from profound hopelessness, despair, and suicidal urges.[8 11 12] Doctors face complex ethical challenges in balancing the responsibility to provide care without discrimination to a vulnerable group against the risk of becoming complicit in a system that by its very nature causes psychological harm. Questions remain whether it is possible to offer effective psychiatric treatment in a setting—prolonged detention—that is the root cause of the mental disturbance. Doctors also face the ethical dilemma of how to respond to requests by authorities to certify asylum seekers as fit to be detained or to be forcibly removed.

Australian professional bodies, particularly the Royal College of Psychiatrists, have advised their members not to become employees of the private company running detention centres, encouraging them instead to offer consultancies as independent professionals. Similar guidance would be useful in the UK.

Every nation has a duty and a right to monitor those who cross its borders. Nevertheless, considerations of national security need to be balanced against our obligations to treat asylum seekers with justice, dignity, and humanity in the spirit of the UN Refugee Convention (1951). Policies of detention were introduced in the 1990s primarily to deter asylum seekers entering Western countries at a time when the number of displaced persons reached a peak. There is no evidence that the policy has worked, as the decline in numbers of asylum seekers is more likely to reflect the historical flux in levels of conflict and population displacement worldwide. It should be noted too that the UK has a relatively low intake of asylum seekers per head of population compared with Germany, the United States, Australia, and France.[1] Intemperate claims in the media that Britain faces a deluge of asylum seekers and that refugees may be terrorists serve only to increase the risk that "tough" and ultimately damaging measures will be implemented, aimed to allay public fears rather than to confront the genuine psychosocial needs of people fleeing persecution.

The lessons for Britain are clear. Australia represented the vanguard of the detention policy in the developed world, yet its present administration has acknowledged the failure of that approach. There is ample evidence that models of community accommodation for asylum seekers lead to better mental health outcomes and that humane but rigorous forms of monitoring can still be instituted in these settings.[13] By continuing to document the psychosocial impact of detention, the medical profession is well placed to add its expert voice in shaping humane immigration policies.

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