

PS02/21

Detention of people with mental disorders in immigration removal centres (IRCs)

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POSITION STATEMENT

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Executive summary

It is the view of the Royal College of Psychiatrists that people with mental disorders should only be subjected to immigration detention in very exceptional circumstances. If a detainee is transferred to hospital during immigration detention, every attempt should be made to avoid a return into immigration detention. There is substantial and consistent research evidence that detainees with pre-existing vulnerabilities (e.g. mental health issues or survivors of torture and other forms of cruel or inhumane treatment, including sexual violence and gender-based violence) are at particular risk of harm as a result of their detention. Detention centres are likely to precipitate a significant deterioration of mental health in most cases, greatly increasing suffering and the risk of suicide.

Despite improvements, we remain concerned about the limitations of being able to provide mental health care successfully within the context of immigration detention. Despite improvements, we remain concerned about the limited nature and extent of the mental health care that can be provided in the immigration detention setting. Furthermore, treatment of mental illness requires a holistic approach and continuity of care; it is not just the treatment of an episode of mental ill health but an ongoing therapeutic input focusing on recovery and relapse prevention. Psychotropic medication by itself is very unlikely to achieve good outcomes unless it is given as part of a broader multi-modal therapeutic approach. Detention also severs the links with family and social support networks, adversely affecting recovery. For these reasons, the recovery model cannot be implemented effectively in a detention centre setting.

Additionally, it is crucial that clinical and other staff working in detention centres are given adequate training and support and that they are offered regular supervision. There should be regular training for all Home Office and healthcare staff on early indicators of mental health conditions and the circumstances in which capacity assessments should be triggered.

Background

In 2013, following a number of cases where it was found by the High Court that the immigration detention of individuals with severe mental illness had breached their rights under Article 3 of the European Convention of Human Rights (ECHR) (the prohibition of torture and inhuman and degrading treatment), a statement was issued on the detention in IRCs of people with mental disorders (Working Group on the Mental Health of Asylum Seekers and Refugees, 2013). The relevant Home Office policy at the time was that people subject to immigration detention who have a mental disorder and could not be satisfactorily managed in detention should only be detained in very exceptional circumstances. The statement addressed common effects of detention on several mental disorders before addressing the question of whether mental disorders can be “satisfactorily managed” in detention.

In the past five years, the policy on detaining those with a mental disorder for immigration purposes has gone through a number of changes. The policy currently applicable is the Adults at Risk Statutory Guidance (Home Office, 2018) and associated caseworker guidance (Home Office, 2019). The Adults at Risk policy was introduced by the government in response to the highly critical Shaw Report (2016) which indicated that previous safeguards were failing. The new statutory guidance had the expressed intention of improving protection from detention for vulnerable people and ensuring that fewer such people would be detained for shorter periods of time.

The 2016 Shaw Report also made a number of recommendations specifically addressing the situation of persons with a mental disorder. These included adding a number of new categories to the existing protected categories, including people with PTSD and intellectual disabilities. Crucially, the report echoed the recommendation of the Working Group on the Mental Health of Asylum Seekers and Refugees, 2013), that people with mental disorders should only be detained in very exceptional circumstances, without requiring further evidence that their health could not be “satisfactorily managed in detention”.

Working group

This Position Statement was prepared by the College Working Group on the Mental Health of Asylum Seekers and Refugees. Membership of the Working Group is as follows:

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The current policy

The current government policy, as set out in the Adults at Risk guidance, centres around indicators of vulnerability, including persons “suffering from a mental health condition or impairment (this may include more serious learning difficulties, psychiatric illness or clinical depression, depending on the nature and seriousness of the condition)”, victims of torture, those who have “been a victim of sexual or gender-based violence, including female genital mutilation”, those who have “been a victim of human trafficking or modern slavery” and those “suffering from post-traumatic stress disorder (which may or may not be related to one of the above experiences)”.

Once a person has been identified as having an indicator of risk, the Adults at Risk policy identifies three levels of evidence for that risk:

- Level 1: self-declaration
- Level 2: professional evidence (including medical evidence) that the person is at risk
- Level 3: professional evidence (including medical evidence) that a period of detention would be likely to cause harm, for example by exacerbating the individual’s pre-existing psychiatric condition.

The level of evidence is used as a measure of degree of risk, which is then weighed against a range of immigration factors when making a decision regarding whether to continue to detain the person.

The Royal College of Psychiatrists welcomes the recognition by the Home Office of the particular vulnerability of people with mental disorders to the effects of detention. We are, however, concerned by a number of issues:

- 1 Level of evidence does not equate to level of risk/vulnerability. People with significant mental illness may have particular difficulty in being effective self-advocates. Their very vulnerability may prevent them from providing adequate evidence for that vulnerability.
- 2 We are concerned that, in practice, evidence at Levels 1 and 2 has often been held to be outweighed even by relatively minor adverse immigration factors. To benefit from a strong presumption against detention, it appears that specific evidence is required showing that detention is likely to cause harm. In our view this creates the same risks as the previous requirement for detainees to demonstrate that they could not be “satisfactorily managed” in detention.
- 3 Recent experience suggests that persons with significant mental illness, as well as those with evidence of past torture, sexual or gender-based violence and those with PTSD, remain detained despite their mental health-related vulnerability and that their mental health deteriorates in detention.
- 4 Detainees who may lack the mental capacity to make decisions relating to their detention and related immigration situation, do not have access to a robust assessment process or, if identified as lacking relevant capacity, to a system designed to safeguard them or to advocate for them in their best interest.

Mental disorders among asylum seekers and people in detention centres

When considering any policy on managing mental illness, it is important not to restrict this to the management of mental illness but to consider a broader concept of mental disorder that would also include people with intellectual disabilities and people with neuro-developmental conditions such as autism etc. The Mental Health Act (2007) also allows for such a broader categorisation which recognises the mental health-related needs of this population.

Research suggests that a high proportion of immigration detainees display clinically significant levels of depression, PTSD and anxiety, as well as intense fear, sleep disturbances, profound hopelessness, self-harm and suicidal ideation. A systematic review of the literature by Robjant et al (2009a) also reported a high prevalence of mental disorders and the use of psychotropic medications among detainees. The most recent review by von Werthern et al (2018) updated the previous review by Robjant et al and found 21 additional studies which were not included in the 2009 review. The new review again reported severe mental health consequences amongst detainees across a wide range of settings and jurisdictions, and summarised further evidence demonstrating the link between duration of detention and severity of mental health symptoms. Additionally, greater trauma exposure prior to detention was associated with symptom severity. The recommendations from this study included increased focus on the identification of vulnerability and on minimising the duration of detention.

Clinically, it is unsurprising that the prevalence of mental illness is high in immigration detainees who are likely to have experienced stressful life events that probably acted as a predisposing factor to their mental illness. These may have included detention (and associated torture) in their country of origin, or during their journey to the UK, and multiple traumatic bereavements and separations. Mental health problems are therefore highly prevalent among detained asylum seekers as a whole (Robjant et al, 2009b; Sen et al, 2017). Being in a detention centre is likely to act as a painful reminder of their past traumatic experiences and to aggravate their fears of potentially imminent return. Family integrity is a crucial factor in maintaining mental health and separation should be avoided wherever possible. Separation from social and professional support is also likely to have a negative impact on detainees' mental state. Under these circumstances, therefore, most existing mental health disorders are likely to deteriorate significantly in detention.

Treatment of mental illness requires a holistic approach and continuity of care; it is not just the treatment of an episode of mental ill health but an ongoing therapeutic input focusing on both recovery and relapse prevention. Treatment offered within such a setting may be able to reduce symptoms and reduce risk to some extent but cannot offer the long-term holistic model of care which will promote full recovery. Furthermore, detention itself is likely to trigger memories of previous traumatic experiences and may also increase distress through the threat of impending removal or deportation. Success of treatment is dependent on the development of therapeutic relationships, providing a multi-disciplinary and multi-agency intervention, and using a biopsychosocial model of therapeutic intervention.

Management of the complex conditions that are often present in asylum seekers may also require more specific specialist therapeutic interventions that may not be routinely available in detention. When an asylum seeker is transferred to hospital for treatment, and benefits from that treatment, there is often a relapse and worsening of their condition once returned to detention. In such cases, a return to detention must be avoided in most cases as it risks undoing the beneficial effect of hospital treatment. Crucially, a background context of basic physical and emotional security, including an assurance of safety and freedom from harm, is a key factor in recovery from most if not all mental disorders. Many people with a mental disorder will not even be able to engage in specialist psychological treatment without this. This sense of safety is further enhanced if all attempts can be made for the asylum seeker to be treated by the same primary care or secondary mental health care team if receiving treatment prior to detention, as discontinuity of care can be a key obstacle to achieving full recovery.

The effect of detention on those with a mental disorder

There is substantial and consistent research evidence that detainees with pre-existing vulnerabilities, e.g. mental health issues or survivors of torture and other forms of cruel or inhuman treatment, including sexual violence and gender-based violence, are at particular risk of harm as a result of their detention (Bosworth, 2016).

The estimated percentage of people self-harming in immigration removal centres during a 12-month period was 12.79% compared to 5–10% for the prison community (Cohen, 2008). However, it is likely that there has been an increase in the rate of self-harm in IRCs. More recent figures published in the second Shaw Review Report (2018) suggest at least 30 detainees per month are on ‘constant watch’ every month. Those at risk of self-harm and suicide are placed on a risk reduction protocol known as Assessment and Care in Detention and Teamwork (ACDT).

The current situation is extensively updated in the second Shaw Review Report, where it is stated that a high-level partnership agreement between NHS England, Public Health England (PHE) and the Home Office was completed and approved by the NHS England Chief Executive in November 2017.¹ This was following an analysis of mental health services completed by the Centre for Mental Health in 2016 and published in January 2017. Developments have included work being undertaken on the review of deaths in custody and deaths in the detention estate, with a dedicated multiagency group and a research programme on deaths in custody being undertaken by Manchester University, which includes the immigration detention estate². It is the view of the Royal College of Psychiatrists that the standard of healthcare provision should be the same for detainees as is found in other NHS settings. The NHS commissioning model described earlier should go some way towards achieving this, as positively commented on in the most recent Shaw Review (2018). All providers of healthcare in detention centres are now part of a national framework of care, standards and inspection, which is an improvement on the previous system of subcontracting via custodial suppliers.

However, despite this positive development, there remain limits on the extent to which mental health care can be successfully provided within the context of immigration detention. As set out in 2013 statement by the Working Group on the Health of Asylum Seekers and Refugees, there are many reasons for this:

- The fact of detention impedes community rehabilitation: The focus of current NHS services is on recovery from the mental disorder; such a recovery model does not just treat the symptoms of the mental disorder but also focuses on community rehabilitation, i.e. being able to function in society, able to care for self, able to work etc. Clinical formulations and treatment plans generally incorporate a biopsychosocial model of mental disorder. Thus, any satisfactory therapeutic intervention plan should incorporate biological, psychological (including psychodynamic) and social components. Such a plan should also aim to minimise any biological, psychological

¹ The healthcare in Dungavel House in Lanarkshire is managed by Med-Co Group.

² The majority of the immigration detention centres are based in England, apart from Dungavel House in South Lanarkshire – Scotland.

or social factors that contribute to the maintenance or worsening of the individual's mental illness.

- Biological treatments include: psychotropic medications; management of associated physical conditions; monitoring of mental state and side effects and specialist treatments, such as electro-convulsive therapy (ECT). Psychological treatments include: supportive counselling; various forms of cognitive and behavioural therapies; specialist psychological interventions; psychotherapies etc. Social interventions include: ensuring an appropriate social and living environment; ensuring social support including that from family; promoting a social network and developing community rehabilitation pathways with the help of occupational therapy. These treatments are ideally integrated by a care co-ordinator or key worker working as part of a multidisciplinary community mental health team linking with social services and voluntary sector agencies. Without an integrated care plan, biological treatments are likely to be of limited effect. In particular, psychotropic medication in itself is very unlikely to achieve good outcomes unless it is given as part of a broader multi-model therapeutic approach. It is worth bearing in mind that the experience of detention itself is likely to be a barrier to the achievement of full recovery following treatment.
- Environmental factors: Factors known to have an adverse effect on recovery include being in an inappropriate therapeutic environment (such as a detention centre) and lack of social, family and other support networks. Detention centres are far fewer in number compared to prisons and more likely to be in locations far away from the asylum seekers' support networks. Other adverse environmental factors include exposure to high expressed emotions (staff need to be trained to understand and deal with people with high emotional needs), lack of specialist therapeutic interventions and lack of adequate monitoring.

For the above reasons, the recovery model cannot be implemented effectively in a detention centre setting. The very fact of detention (which, unlike imprisonment, has no punitive or retributive function) also mitigates against successful treatment of mental illness, for the reasons described earlier.

Post-traumatic stress disorder

PTSD symptoms are particularly likely to be aggravated by detention, triggering reminders of the original trauma. This is especially the case if asylum seekers have previously been detained, kept in isolation, tortured and/or deprived of their liberty as a result of human rights abuses such as torture, trafficking or enforced domestic servitude, prior to their immigration detention. In these cases, the very fact of being detained, and associated factors such as being in a cell, seeing officers in uniform, the sound of keys jangling, heavy footsteps or doors closing or being locked and unlocked, will trigger intrusive memories of their previous traumatic experience – and, for some, reliving experiences and flashbacks (when they experience past events as happening in the present). This is a significant source of suffering; all the symptoms of PTSD, including debilitating fear, insomnia, nightmares, noise sensitivity, intense agitation, autonomic nervous system hyperarousal and dissociative symptoms, are likely to worsen. So too will feelings of helplessness and depression. In this context, the risk of agitation, including self-harm, aggression and suicide, are likely to increase significantly, leading to the high rates of such behaviour being observed in detainees.

Torture survivors have a right to rehabilitation; this cannot be carried out while they are in detention. The Quality Standards for Healthcare professionals working with victims of torture in detention (Faculty of Forensic and Legal Medicine, 2019) contain guidance on the assessment of those with mental health conditions and questions about their mental capacity. In particular, the standards draw attention to the need for a care plan and proper follow-up of detainees to identify their healthcare needs and monitor for the effects of treatment or any deterioration of their condition, as well as the duty of the doctor to raise a concern where their recommendation to release has not been followed.

The treatment of PTSD requires specialist psychological intervention in a setting conducive to a sense of safety and to a growing sense of trust towards the therapist. Though trauma-focused therapy is not possible in the detention setting, individuals in need of such therapy may derive interim benefit from a supportive therapeutic relationship in which they can work towards longer-term external goals such as building relationships, engaging in social activities and developing educational and occupational skills. A community context and an atmosphere in which they can increasingly focus on their future and stop thinking about the past is key to this work. This is, however, also difficult to achieve in a detention situation where the very fact of detention and the imminent risk of return is a constant preoccupation, acting as perpetuating factors for the individual's fears and symptoms.

Depression

Asylum seekers often also have significant symptoms of depression and anxiety, which may occur independently or coexist with PTSD symptoms as part of a complex traumatised state. Many have suffered multiple traumatic losses including bereavements and separation from loved ones and loss of home, status and identity in their country of origin. Such losses are well recognised as predisposing, precipitating and/or perpetuating factors in severe and recurrent depressive illness, and are often further compounded by the poverty and emotional isolation of asylum seekers in the UK. Uncertainty regarding asylum status, and fear of impending removal/deportation, are further factors likely to contribute to depressive and/or anxiety symptoms. This makes it very difficult to sustain hope, leading to a chronic state of helplessness and despair and, potentially, increased risk of suicide.

Unfortunately, all these factors are likely to be exacerbated by detention. In particular, the unpredictable event of arrest, the indefinite period of stay and the threat of imminent return will exacerbate helplessness and a state of intense fear. Detainees are also likely to suffer further loss of hope or motivation, particularly in relation to their reduced sense of safety and inability to work towards their future life goals associated with staying in the UK. This further increases their risk of suicide.

Significantly, when detained, asylum seekers also suffer loss and separation from the therapeutic and social networks they may have built up in the community since they have been in the UK. This would in itself be sufficient to cause deterioration in their mental state because it constitutes a loss of therapeutic and sustaining factors which may be protecting against further deterioration and providing motivation to stay alive and recover. However, in addition, losses and separation in the present are also likely to trigger feelings associated with losses in the past, again increasing the likelihood of deterioration and potentially risk of self-harm and/or suicidal ideation.

Psychosis

People with pre-existing psychoses, such as schizophrenia, are likely to deteriorate due to the high expressed emotion in an environment with other frightened and angry fellow detainees. They are also at increased risk of suicide. Many asylum seekers who have PTSD may experience transient secondary psychotic experiences which are typically precipitated by stress. They may be triggered by the stress of detention, as a result of which they may lose the capacity to distinguish flashbacks of persecutory events from current reality and can become acutely paranoid, believing they are being pursued by persecutors in the present with associated complex visual and auditory hallucinations. If transferred to a hospital setting for treatment of psychosis, there is a high risk that they may deteriorate again if returned to the detention setting following successful treatment.

Intellectual disability, autistic spectrum disorders and ADHD

People with intellectual disability (ID) may present with concurrent mental illness. Detection both of the ID and of the associated mental illnesses requires particular clinical skills. These individuals require specialist input from professionals with experience in the recognition and management of mental disorders in ID, which is unlikely to be available in the immigration detention setting. People with autism spectrum disorders (ASD) are particularly likely to present with high levels of anxiety and/or agitation. This may be misunderstood as challenging behaviour, leading to a vicious circle of increasingly restrictive containment and worsening behaviour. Such individuals would benefit from structured routines and an appropriate environment tailored to their sensory needs. The same is true of asylum seekers with attention deficit hyperactivity disorder (ADHD) which is often not properly diagnosed and treated within an immigration detention setting. Studies suggest a significant prevalence of these conditions within immigration detention centre populations (Sen et al, 2019).

Survivors of torture

The available published evidence, summarised in our 2016 Position Statement (Royal College of Psychiatrists, 2016) and explored in a comprehensive review of the academic literature pertaining to the impact of immigration detention (Bosworth 2016), shows that a history of torture alone predisposes an individual to a greater risk of harm, including deterioration in mental health and increased risk of anxiety, depression and PTSD, than would be experienced in the general detained population. The systematic review by Von Werthern et al (2018) came to the same conclusion. Similar considerations apply to survivors of human trafficking/modern slavery, whose ill-treatment can be considered equivalent to torture (OSCE Office et al, 2013). The research evidence also indicates high rates of mental illness (including PTSD) in survivors of human trafficking/modern slavery (Ottisova et al, 2016).

Identification of mental illness

Mental deterioration in detainees with pre-existing mental illness needs to be identified consistently and promptly to ensure that they receive appropriate treatment and that where appropriate (which is likely to be in the majority of cases) they are released and thereby protected from further harm. This requires training for staff on the indicators of mental illness as well as the indicators of deterioration and access to appropriate assessment/expertise. Historically concern has been raised that behaviours reflective of mental illness have too readily been misattributed to attention seeking³. In our collective experience this has often been the case. When viewed against the background evidence of rates of mental illness in detention and the known effects of detention on those with pre-existing mental illness, the consistently low numbers of Rule 35(1) Reports⁴ also suggest that problems with the identification of mental illness, deterioration in mental health and the risk thereof, remain. The use of Rule 35 to identify deterioration in mental health and/or escalating suicide risk should be expanded.

The following signs may indicate that an individual has a mental health condition or that their mental health may be deteriorating:

- self-harm or suicidal thoughts
- a change in behaviour, such as becoming agitated, being low in mood, being quiet, being boisterous, becoming tearful, being angry
- becoming disorientated or experiencing confused thinking
- feelings of extreme highs and lows or excessive fears, worries and anxieties
- strange thoughts (delusions)
- seeing or hearing things that aren't there (hallucinations)
- changes in sleeping or eating habits (other than cultural needs), e.g. refusing food and/or fluids, binge eating, excessive exercise
- poor self-hygiene
- growing inability to cope with daily problems and activities
- social withdrawal.

3 Jeremy Johnson QC found in his appendix to the Shaw Review (2016) "There are cases where the Courts have found that detainees have behaved violently and abusively simply to resist removal. It might not be surprising if case-hardened decision makers developed an overly cynical attitude towards those displaying challenging or bizarre behaviour. Such behaviour might be voluntary and deliberately intended to thwart removal. Or it might be attributable to a mental illness and an indicator that continued detention is injurious to health. For a lay person it may be impossible to tell. There is an indication in the cases of a possible over-willingness simply to assume that such behaviour is intended to resist removal and not to countenance the possibility that it is due to an underlying illness."

4 Rule 35(1) of the Detention Centre Rules 2001 require a report to be completed in the case of each detainee who is likely to be injuriously affected by detention (<http://www.legislation.gov.uk/ukxi/2001/238/contents/made>). In the second quarter of 2019 seven Rule 35(1) reports were completed. During the same time period there were 538 reports relating to concerns a detainee may have been a victim of torture.

Delay in identifying mental illness and the risk of and presence of actual deterioration in mental health leads to delays in this information being considered in reviews of continued detention and therefore very likely leads to further deterioration in mental health and increased suffering of the individual. It is also likely to lead to a delay in the commencement of treatment. In the case of psychosis there is consistent research evidence that this delay in itself leads to worse long-term prognosis and therefore increased suffering and reduced quality of life (Perkins et al, 2005).

People who lack relevant decision-making capacity

Our concerns about the detention of people with mental disorders who may lack decision-making capacity have been expressed in detail in our Position Statement on capacity (Royal College of Psychiatrists, 2017). Individuals experiencing symptoms of a mood disorder (anxiety, depression, PTSD) or of a psychotic disorder can experience distorted cognitions. In a psychotic disorder, this could be due to delusional beliefs and in a mood disorder it could be due to pervasive negative cognitions. Such distorted cognitions may impact on the individual's ability to appropriately weigh and balance information given to them. Such deficits may be difficult to ascertain, as the individual may express a consistent and coherent answer to a question, e.g. refusing medication that is offered, and therefore the cognitive processes underlying such a choice are not explored.

Cognitive deficits relating to intellectual disability and to dementia are more likely to affect an individual's ability to understand information given to them and their ability to express a consistent opinion. This type of decision-making deficit may be more obvious to a healthcare professional than the test of weighing/balancing invoked in the 2005 Mental Capacity Act, because the individual will either not answer or clearly does not understand the question. Whatever the nature of the deficit, healthcare professionals have a duty to assess and document decision-making capacity in individuals under their care. The existing evidence (medical, legal and governmental reports) gives rise to serious concern that both pre-existing mental health disorders (which are likely to be aggravated by detention) and those arising de novo in detention may result in detainees losing decision-making capacity with regard to healthcare and legal matters⁵, and that the processes in place within IRCs to address these phenomena are not sufficiently robust. This has resulted in a situation where an already vulnerable population is less likely to receive appropriate healthcare for their mental health disorders and therefore to be impeded in accessing legal remedies. Independent advocacy services are lacking. This may result in prolongation of their detention – which in turn leads to worse outcomes.

Given the high risk of deterioration of mental illness in detention and, in turn, of disturbed behaviour, self-harm and suicide associated with such deterioration, it is crucial that the clinical professionals involved, and the staff providing ongoing care, are able to identify and monitor the risks and develop appropriate strategies and care pathways to manage this adequately. Appropriate structures are required to ensure support for individuals who lack capacity to navigate not only accessing healthcare treatment but also processes relating to their detention, conditions of detention and immigration processes. These are summarised in the Quality Standards for Healthcare professionals working with victims of torture in detention.

5 In relation to healthcare these would be treatment and diagnosis, in relation to legal matters these may be the ability to instruct a lawyer, to engage with the asylum or immigration process including consideration to making applications for release from detention and decisions related to processes within detention such as segregation reviews.

Support for staff

Adequate support for staff working in such settings is crucial. There could be significant impact on staff of the detainees' traumatic experiences, what is called vicarious traumatisation or secondary traumatic stress. This could have a significant emotional impact on staff and they might deal with it either by being completely withdrawn and avoidant or by being over-involved and over-identify with the experiences of the detainee (Willson, 2004).

Good supervision, preferably offered by somebody external to the organisation, offered individually or in groups, is crucial to reduce the risk of burn out, allowing staff to maintain a degree of therapeutic self-awareness. What is also extremely important is to allow opportunities for continuing professional education to avoid professional isolation and enable staff to keep a balance between empathy and proper professional distance from clients.

Any pressure, or perceived pressure, on clinical staff to participate in the removal process, for example by returning patients from hospital sooner (Mental Welfare Commission for Scotland, 2018), undermines the professional expertise of clinical staff, risks encouraging poor care and is likely to be inimical to staff morale.

Conclusions and recommendations

In the judgement *Aswat v UK*⁶, the European Court of Human Rights (ECHR) observed that both the fact of detention of a person who is ill and the lack of appropriate medical treatment may raise Article 3 issues (i.e. may constitute inhuman or degrading treatment).

There are three main elements to be considered in relation to the compatibility of an individual's health with her/his stay in detention:

- the individual's medical condition
 - the impact of detention on the individual's health
 - the adequacy of the medical assistance and care provided in detention.
- 1 People with mental disorders should only be subjected to immigration detention in very exceptional circumstances. Even in such circumstances the length of detention should be minimised and the availability of alternative settings considered at every stage.
 - 2 Detention centres are likely to precipitate a significant deterioration of mental health in the majority of cases, greatly increasing both the suffering of the individual and the risk of suicide and self-harm.
 - 3 Individuals with mental disorder are entitled to receive the same optimum standard of care if they are in a detention centre as they would in any other NHS setting though, as noted above, the very fact of detention makes this impossible.
 - 4 Detention centres are not appropriate therapeutic environments to promote recovery from mental ill health, due to the nature of the environment and the lack of specialist mental health treatment recourses. The indefinite nature of detention further exacerbates the detrimental impact of detention on mental health.
 - 5 The current ethos of mental health services is on recovery and community rehabilitation, which cannot be fully provided in a detention centre where treatment has to focus primarily on treatment of symptoms and reduction of risk.
 - 6 It is crucial that clinical and other staff working in detention centres are given adequate training and support to identify mental disorder when it does arise, or deteriorates significantly in a detention centre setting, and clear guidelines on how to manage this appropriately and link up with existing local mental health provision outside the detention centre. This should include specific attention to appropriate monitoring and management not only of risk but also of recovery.
 - 7 It is also crucially important that clinical and other staff working in detention centres are offered regular supervision, either individually or in groups, preferably by somebody external to the organisation, and provided with adequate access to continuing professional education.
 - 8 The provision of care in IRCs should link with existing local mental health provision outside the detention centre, with clear protocols for communication of clinical

⁶ *Aswat v UK* app no 17299/12, ECHR, 16 April 2013.

information and transfer of care if required. All attempts should be made to ensure continuity of care, both within primary and secondary healthcare services. This requires proper discharge arrangements to be made prior to release. Transfer to hospital should be carefully planned to minimise the need for restraint during the journey which can cause a great deal of distress.

- 9 There should be regular training for all Home Office and healthcare staff on early indicators of mental health conditions and the circumstances in which capacity assessments should be triggered. This should be linked to safeguarding training along with the development of a screening tool for assessment of capacity for all detainees and robust pathways including the provision (in keeping with the conclusions of the Mental Welfare Commission for Scotland, 2018) of appropriate advocacy services for those found to lack mental capacity to make relevant decisions.
- 10 If a detainee is transferred to hospital during immigration detention, every attempt should be made to ensure good working relationships between IRCs and hospital staff to ensure that return to immigration detention following successful treatment is avoided – because otherwise the benefits of treatment in hospital risk being undone by the return.

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