'Protection or punishment?' The implications of detention on the mental health and well-being of migrants, a review of the literature.

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Abstract

Background: The number of individuals forced to leave their home and seek asylum in other countries has risen alongside political instability, conflict and persecution in many parts of the world. These individuals are therefore extremely vulnerable. Many asylum-seekers have witnessed and experienced traumatic events that have contributed to mental illness. Detention is often used to incarcerate asylum-seekers who are waiting for asylum decisions to be made, however many are held in inadequate conditions for long periods of time. With governments using immigration detention increasingly more often, there are serious questions surrounding the impact this has on the mental health of detainees.

Methods: A systematic review was undertaken using a comprehensive search strategy across six databases. Both qualitative and quantitative studies were included in the review providing that the mental health implications of immigration detention were explored or measured. Grey literature was also searched. The quality of the included studies were appraised and a narrative synthesis conducted in order to establish the main findings of the review. The results of the narrative synthesis were included in a conceptual model that explains how detention works to influence mental health.

Results: 22 studies were included in the review. Six themes were identified from analysis of study findings from around the world. Five of those themes also occurred within studies conducted within the UK. In both the UK and globally: detention was associated with poor and deteriorating mental health outcomes; specific conditions inside detention centres were found to contribute to poor mental health; longer durations spent in detention were associated with poorer mental health outcomes; several negative behavioural and emotional responses to the detention experience were observed – particularly in children; the trauma of detention and mental health difficulties developed while in detention remained with individuals after release. In addition to these five themes, a higher number of relocations between detention centres contributed to greater mental distress among detainees outside the UK.

Conclusions: This review provides evidence to suggest that an association exists between immigration detention and poor mental health outcomes and that many of the mediators of this relationship are universal. The findings of this paper have several implications for further research and policy. The UK must end indefinite detention and move towards alternative solutions for dealing with asylum-seekers. Detention should only be used as a last resort. Vulnerable individuals, such as children and individuals with existing mental health issues should never be detained. Finally, greater care should be taken to ensure that families with young children are not separated from one-another. Due to the implications of the findings

included in this review, it is vital that scientific research of this type is allowed to continue. Future research must evaluate the feasibility and suitability of alternative policies to detention.

List of abbreviations

MOA - The Community Health Services for Asylum Seekers

PTSD – Post-traumatic Stress Disorder

EU – European Union

OECD - The Organization for Economic Cooperation and Development

QOL – Quality of Life

NGO – Non-governmental Organisation

AVID - Association of Visitors to Immigration Detainees

BID – Bail for Immigration Detainees

GDWG - Gatwick Detainees Welfare Group

UNHCR - United Nations High Commissioner for Refugees

NHLBI - National Heart, Lung, and Blood Institute

CASP - Critical Appraisal Skills Programme

MMAT - Mixed Methods Appraisal Tool

IRC – Immigration Removal Centre

IHC – Immigration Holding Centre

PPV - Permanent Protection Visa

TPV – Temporary Protection Visa

OCD – Obsessive Compulsive Disorder

ICPC - International Classification of Primary Care

DIAC - Department of Immigration and Citizenship

SDQ - Strengths and Difficulties Questionnaire

ICD-10 - 10th revision of the International Statistical Classification of Diseases and Related Health Problems

HTQ-IV - Harvard Trauma Questionnaire, part IV

HSC-25 - Hopkins Symptom Checklist-25

GHQ-30 – General Health Questionnaire, 30-items

PSWQ – Penn State Worry Questionnaire

SCAS - Spence Children's Anxiety Scale

DSRS – The Birleson Depression Self-Rating Scale

ANCOVA – Analysis of Covariance

WHOQOL-BREF – World Health Organisation Quality of Life-BREF

AMHOCN - Australian Mental Health Outcomes and Classification Network

ISIL – Islamic State of Iraq and the Levant

PICOS – Population; Intervention; Control; Outcome; Study type

SPIDER – Sample; Phenomenon of Interest; Design; Evaluation; Research type

AS – Asylum-seeker

RE – Refugee

IM – Illegal migrant

LM – Labour migrant

Definitions

Immigration detention – *‘the policy of holding individuals suspected of visa violations, illegal entry or unauthorised arrival, and those subject to deportation and removal in detention until a decision is made by immigration authorities to grant a visa and release them into the community, or to repatriate them to their country of departure’.*

Mandatory detention – *‘Mandatory detention is the practice of compulsorily detaining or imprisoning people seeking political asylum, or who are considered to be illegal immigrants or unauthorised arrivals into a country’.*

Migrant – *‘a person who moves from one place to another in order to find work or better living conditions’.*

Asylum-seeker – *‘a person who has left their home country as a political refugee and is seeking asylum in another’.*

Refugee – *‘a person who has been forced to leave their country in order to escape war, persecution, or natural disaster.’*

Temporary Protection Visa – *‘an Australian visa document issued to persons who applied for refugee status after making an unauthorised arrival in Australia, it is the main type of visa issued to refugees when released from Australian immigration detention facilities.’*

1 INTRODUCTION

1.1 BACKGROUND

In 2016, there are currently more displaced people than ever before – 65.3 million¹ individuals have been forced to leave their country of birth due to ongoing conflict and persecution. This has been encapsulated by the ‘refugee crisis’ affecting millions of individuals fleeing from Syria in an attempt to escape the atrocities committed by Assad, ISIL, and governments who have sanctioned airstrikes resulting in thousands of civilian deaths. Western governments, while quick to condemn the ongoing violence, continue to use, and have scaled up the use of policies that attempt to prevent those forcibly displaced from their own countries from entering the country.² Individuals waiting for their asylum claim to be processed often face restricted access to health and welfare services, enforced dispersal and social exclusion, complicated and strict asylum procedures as well as mandatory detention until a decision has been reached about their asylum claim³. Similarly, there is much speculation that the UK’s recent exit from the European Union was achieved in part by the ‘refugee crisis’ in Europe and the fear that many displaced individuals would be permitted to reside in the UK under the EU’s free movement of people agreement.⁴ There is a pattern of increasing reluctance to help those fleeing from war and persecution. The focus of this review surrounds the controversial health impacts of one of these practices that has the dual function of 1) preventing foreign nationals who do not have a valid visa from living in the community and 2) facilitating their expulsion – this practice is called immigration detention.⁵

1.1.1 Mental health of asylum seekers

Many of those forcibly displaced from their country of residence have witnessed conflict and experienced interpersonal-trauma⁶ such as torture, sexual abuse, exploitation, the murder of family members, and persecution. This makes those seeking asylum a very vulnerable population. Studies have shown that the mental health of asylum-seekers and refugees is extremely poor and that pre-migration experiences such as exposure to trauma contribute significantly to the prevalence of psychiatric symptoms among individuals⁷⁻¹⁰. Individuals seeking to claim asylum in a host country face lengthy, bureaucratic and stressful procedures that they are emotionally and culturally unprepared to deal with.¹¹ Interviews that interrogate individuals about their right to claim asylum are particularly damaging for those suffering from PTSD and other psychiatric disorders and can exacerbate symptoms. The vulnerability of this population necessitates asylum claims to be dealt with sensitivity

supported by sound legal advice and emotional support, however many asylum-seekers face this process alone and are subjected to extreme isolation and corrosive environments.¹¹

1.1.2 Detention

The rules surrounding the detention of individuals entering a new country vary from country to country and are constantly changing – often due to shifts in a government's political ideology. For example, since 1992 the Australian government has implemented mandatory detention for all individuals seeking political asylum; it is the only OECD member state to do so.¹² Australia is also the only country to use remote, offshore detention centres to incarcerate non-citizens deemed to have violated visa procedures or who have entered the country illegally. Foreign nationals seeking asylum can therefore be detained in a number of different circumstances:

- Upon entry to the host country
- While the decision for their asylum claim is being processed
- After the claim for asylum has been rejected and individuals are awaiting removal to their home country.¹³

Although the practice of immigration detention has always been controversial, it is only now that pressure from the general public, physicians, lawyers and even independent reports commissioned by members of parliament have spawned a climax in the dialogue surrounding immigration detention. This has followed from accounts of severe human rights violations inside detention centres, including widespread abuse, sexual assault, violence, and trauma that have been leaked into the public sphere despite governments' best attempts to contain such information.¹⁴

1.1.3 Immigration detention in the UK

The UK is the European Union's biggest detainer of migrants with over 32,000 individuals entering detention centres during the period from June 2014 – June 2015.¹⁵ There are more adults in detention in the UK than at any other period in history and this figure continues to grow year after year. Although the number of children in detention has dropped since 2010, there were still 155 children detained within UK immigration detention centres in June 2015. The UK has eleven immigration detention centres that are scattered around various parts of the UK – the latest opening in September 2014. The UK, along with Australia is one of the few countries that does not have a time limit on how long individuals can be detained. As a result, there are an increasing number of individuals that are incarcerated for unacceptable periods of time. At the end of June 2015, 216 individuals released or removed from detention had been incarcerated for longer than one year – 29 of these for longer than 2 years.¹⁵

There is therefore a worrying disparity between these revelations and the Home Office's statement regarding the use of detention:

“Detention must be used sparingly, and for the shortest period necessary.”¹⁶

1.1.4 Why a systematic review and why now?

Due to the political barriers to accessing this type of population, empirical research in this field has been limited and of a poor methodological quality - with much of the evidence anecdotal in nature. Since the first and only review,¹⁷ there has been an upsurge in media attention surrounding immigration detention and its potentially harmful impacts on the mental health of individuals. A side-effect of this has been an increase the number of studies conducted that aim to explore the mental health impacts of detention as a policy option. Being the first review,¹⁷ naturally there were many areas left unanswered or requiring additional evidence.

To address the gap in research, this study critically appraises the methodological quality of new studies in order to update the evidence of the mental health impacts of immigration detention. It does this through evaluating:

- a) the *independent* impact of detention on mental health
- b) the pathways and mediators of this relationship
- c) the brief and long-term consequences of detention on mental health.

2 AIMS & OBJECTIVES

1. To review the latest international evidence in order to understand the link between the detention of migrants and the impact this has on their psychological health and well-being.

2.1 OBJECTIVES

1. To describe and explain the impact that detention has on the mental health of migrants in countries other than the UK.
2. To describe and explain the impact that detention has on the mental health of migrants in the UK and to examine whether problems faced by UK migrants are similar to those detained in other countries.
3. To assess the quality of the studies (study designs, sample characteristics, exposure and outcome measures).
4. To identify which parts of the detention process in particular have the most severe effects on the psychological well-being of individuals.
5. To gain an understanding of how detention continues to influence individuals' mental well-being after being released.

3 METHODS

3.1 LITERATURE SEARCH

In order to assess all of the relevant evidence of the mental health implications of immigration detention, a systematic literature search was conducted based on a number of inclusion and exclusion criteria. Peer-reviewed literature was searched for through electronic databases and manually through reference lists of included studies. Grey literature was accessed by searching the websites of parties and organisations that include immigration detention in their remit. This approach was taken to ensure that a wide range of articles were included in the review and to minimise the likelihood of any publication bias.

3.1.1 Inclusion criteria

All studies that comprised either qualitative or quantitative measures of mental health and well-being were included in this review. All papers were required to be published in the English language. The last and only systematic review on this topic¹⁷ used a cut-off date of April 2007. Therefore in this review, only papers published after this date were included. Just as in the aforementioned paper, studies were included regardless of study participants' age or detention status. Studies that measured the mental health of individuals either currently or previously-detained in immigration detention centres or removal centres were eligible for inclusion. Likewise, papers measuring the mental health of children, adolescents and adults were again suitable for inclusion in this review. Qualitative studies that described consecutive case series of more than two cases were included, as were pilot studies. Studies were included in the review irrespective of which country they were conducted in – those that specifically focused on immigration detention within the United Kingdom were included in a separate narrative.

3.1.2 Exclusion criteria

Studies that did not include details of either data collection or analysis methodologies were excluded – e.g. viewpoints published in academic journals. Papers not written in English were excluded from this review. Studies on migrant health in populations who were not detained, studies on the implications of detention on non-migrant populations, studies that measured only the implications of detention on the physical health of migrants, single case studies and review papers were all excluded.

3.1.3 Search Strategy

3.1.3.1 Electronic databases

The electronic database search strategy was based on a modified version of the search strategy used by Robjant et al. (2009b).¹⁷ Synonyms of key words and phrases were added to include a wider range of studies. Electronic databases were accessed between 07.07.2016 and 09.07.2016. The results of the search strategy were updated on 28.07.2016 to see whether any new papers had been published. In total, 6 electronic databases were searched:

- PUBMED (May 2007 to July 2016)
- PsychINFO (May 2007 to July 2016)
- Global Health (May 2007 to July 2016)
- Scopus (May 2007 to July 2016)
- PILOTS (May 2007 to July 2016)
- Web of Science (May 2007 to July 2016)

Search terms used are as follows: ((migrant*) OR (immigrant*) OR (asylum*) OR (refugee*) OR (detainee*)) AND ((detention*) OR (detention centre*) OR (removal centre*) OR (asylum*)) AND ((health) OR (mental) OR (post-traumatic*) OR (PTSD) OR (depress*) OR (anxiety) OR (QOL or “quality of life”). The results of the search strategy are presented fully in **appendix 1**. Duplicate studies between databases were removed using EndNote.

3.1.3.2 Manual search

The bibliographies of papers that met the inclusion criteria were scanned in detail in order to extract any eligible studies not captured by searching electronic databases.

3.1.3.3 Grey literature

Grey literature was also searched in order to examine the evidence of unpublished studies and non-peer reviewed articles – it is hoped that doing this will minimise the likelihood of publication bias in the selection of studies for this review. Grey literature for UK-based literature was accessed through a number of sources. Google searches were conducted using the UK domain. In addition, the websites of a number of organisations, including NGO's, charities, volunteer groups, and government departments were searched for publications and research papers surrounding immigration detention and mental health. These include: AVID; BID; Detention Action; GOV.UK; Gatwick Detainee's Welfare Group; HM Inspectorate of Prisons; Save the Children; Amnesty; and Medecins Sans Frontieres. Publications were included based on the same inclusion criteria as was used in the electronic database search.

3.2 DATA EXTRACTION

Relevant data was extracted from the studies included in this review using a modified data extraction form in Microsoft Excel. Using the PICOS and SPIDER tools as a starting point, information about the: study design; characteristics of the population, nature of the setting, aims of the research, outcome measures, data collection and analysis process, and the key findings of each study was organised into a number of tables. PICOS ('Population', 'Intervention', 'Comparison', 'Outcome', 'Study type') and SPIDER ('Sample', 'Phenomenon of Interest', 'Design', 'Evaluation', 'Research type') are search tools used to identify and extract relevant characteristics of a study. These tools were combined in order to produce summary tables of the particular details of each study. By combining PICOS and SPIDER tools in the extraction of study characteristics, it is hoped that the pertinent characteristics of both qualitative and quantitative studies are captured.¹⁸

3.3 QUALITY ASSESSMENT

The included studies were assessed to determine the overall quality of the research. Because this review includes quantitative, qualitative and mixed-methods studies, three different tools were used to critically appraise the research methods used by researchers and determine the value of their findings. I used the National Heart, Lung, & Blood Institute (NHLBI) quality assessment tool to critically appraise the quantitative studies included. The tool is designed to assess the internal and external validity of observational cohort and cross-sectional studies and has been used appropriately for this purpose.¹⁹ Fourteen questions are included which assess the risk of the potential for selection bias, information bias, measurement bias and confounding. The quality of each individual study was assessed by answering 'Yes', 'No', 'Not Applicable' or 'Not Recorded' to each criterion – these were used to determine the overall quality of the study. Qualitative studies were appraised using the Critical Appraisal Skills Programme (CASP) checklist for qualitative studies. The CASP checklist includes ten questions designed to examine both the credibility and transferability of the qualitative research findings. Each criterion was answered using either 'Yes', 'No', or 'Can't Tell'- the results of which guided the decision on whether the study was of sound methodological quality. The quality of mixed-method studies was appraised using the Mixed Methods Appraisal Tool (MMAT). The MMAT includes thirteen separate criteria and has proven to be suitable for appraising the methodological quality of mixed-method studies.²⁰ Details of the appraisal tools and the results of the quality assessment are detailed in **appendix 2.**

3.4 DATA SYNTHESIS

The studies included in this review are diverse both in regards to the characteristics of the population under study and the outcomes measured. In addition, the quality of the studies included is extremely variable and the risk of potential biases high in some studies and lower in others. It is for these reasons that we decided that the quantitative analysis and integration of results in a meta-analysis was not suitable for this review and was likely to bring about misleading conclusions. It was therefore decided that in order to systematically analyse the findings of each paper and combine them into a single, coherent body of work, a narrative synthesis of the studies' would be most appropriate. The principles used to conduct the narrative synthesis are outlined by Rodgers et al. (2009).²¹ A preliminary synthesis was undertaken by extracting and then tabulating relevant data (**see 3.2 Data Extraction**) from the included studies. Relationships between individual study characteristics and their findings were explored and the findings of different studies grouped into common themes. Using the results of the critical appraisal, consideration was given to the weight of the evidence behind individual study findings to assess the rigour of the synthesis' final output. A conceptual model of how detention influences mental health outcomes was created using the results of the narrative synthesis.

3.5 ETHICS

The proposal for this study was reviewed by the London School of Hygiene & Tropical Medicine board of ethics, it was confirmed that ethical approval was not required.

4 RESULTS

4.1 DESCRIPTION OF THE STUDIES

4.1.1 Results of literature search

The total number of studies searched through electronic databases was 3,091 – of which 1,120 were found to be duplicate studies and were subsequently removed from the search (Figure 1). This left a total of 1,971 studies that were screened. 1,948 studies from the electronic database search were excluded upon reviewing their titles and abstracts. Studies were excluded on the basis that they did not bear significant relevance to the research question and did not meet the aforementioned inclusion criteria. From the electronic database search, 23 studies were selected for further analysis of their full-text.

In addition, 4 peer-reviewed studies were selected for full-text review by manually searching the reference lists of the 15 studies included in the final review. 4 grey literature sources were added through manually searching the websites of relevant organisations.

After reviewing the full texts of the 31 potentially eligible studies, 22 studies successfully met the inclusion criteria and were included in the literature review. Nine studies were excluded for the following reasons:

- ❖ Full-text could not be accessed (n=2)
- ❖ Not enough relevant data (about detention) collected to review (n=2)
- ❖ Focus on staff at detention centres rather than detainees (n=1)
- ❖ Study sample made up entirely of migrant prisoners awaiting deportation (n=1)
- ❖ Not scientific research studies (methodology not scientific) (n=3)

Figure 1 – Flow diagram: search strategy

4.2 INCLUDED STUDIES

Due to word restrictions and the large number of studies included, characteristics of all studies including participant characteristics are included in **appendix 4 & 5**.

4.2.1 Publication type

Fifteen studies were peer-reviewed research papers that were accessed via searching of electronic databases described above. Three peer-reviewed studies were included from the manual search of the reference lists of these fifteen research papers. Four papers included in the review were not peer-reviewed, and were accessed through the specific targeting of known organisations, NGO's and charities that advocate on the behalf of detainees.

4.2.2 Study type

All twenty-two studies were observational in nature, although four studies did include one or more comparison group. Included studies used qualitative or quantitative methodologies and in some cases, a combination of the two. Eleven studies used only quantitative methodologies, seven studies used only qualitative methodologies and the remaining four studies used a mixed-methods study design (however only the qualitative component was deemed relevant for one of these papers). Approaches to data collection and analysis are described at length in **appendix 4**.

4.2.3 Country

Studies were included regardless of the geographical area in which the research was carried out. The idea being that reviews of both international research and research based within the United Kingdom would be conducted and compared to see if the impact of immigration detention was ubiquitous. Fourteen studies looked at the implications of immigration detention on mental health in detention centres outside the UK (Sweden: n=2, The Netherlands: n=1, Australia: n=5, Denmark: n=3, Canada: n=2, and Switzerland: n=1). Eight studies looked at the implications of immigration detention on mental health within the UK.

4.2.4 Participant characteristics

The characteristics of the study participants are described in **appendix 5**. Some studies did not describe the demographics of the study population entirely. In this case, information is left blank.

- Age: Studies were included in the review regardless of the age of the participants due to the relatively small body of research available. Four studies focussed primarily on the mental health and well-being of children in detention, however the participants included in the vast majority of studies were of a normal working age (15 – 65).

- Sex: Studies did not discriminate between genders however, due to the demographics of the refugee and migrant population, the majority of participants included in this review are male.
- Detention status: Fifteen studies measured the well-being of individuals currently detained within IRC's, three studies did not discriminate between detention status, and four studies looked exclusively at the mental health of former detainees. Time in detention differed between studies, with studies considering the implications of brief, long-term, and indefinite detention.
- Ethnicity: Due to the nature of the refugee and migrant population, the populations studied are incredibly diverse and multi-ethnic in almost every study.

4.2.5 Outcome measures

Quantitative studies: Quantitative studies included in this review measured a number of different outcomes in order to determine the full implications of detention on psychological health and well-being. Three studies measured solely objective outcomes such as incidence of newly diagnosed mental distress,²² incidence of new mental health complaints & diagnoses²³ and incidence of new referrals to medical specialists whereby a diagnosis was recorded.²⁴ The remaining studies measured either subjective outcomes or a variety of subjective and objective outcomes. One study measured perceived quality of life (QOL) of individuals in detention.²⁵ The majority of other studies measured symptoms of anxiety, depression, and PTSD. Young & Gordon (2016)²⁶ measured clinical outcome measures of anxiety, depression and PTSD, whereas Steel et al. (2011)²⁷ incorporated the ongoing impact of detention on levels of worry, stress, and presence of negative coping strategies post-release (**Appendix 3**).

Qualitative studies: The qualitative studies explored detainees' experiences of daily life in detention and how they believe these experiences have contributed to their current mental distress and negative emotional outcomes²⁸⁻³³. Klein & Williams (2012),³⁴ Coffey et al. (2010)³⁵ and Kronick et al (2015)²⁸ also explored how the experience of detention has contributed to ongoing mental distress even after detainees were released from IRC's. Connelly et al (2015)³⁶ investigated what factors contribute to vulnerability inside detention centres.

Mixed-methods studies: Coffey et al. (2010)³⁵ measured both quantitative outcomes such as symptoms of anxiety, depression and PTSD and qualitative outcomes including perceptions of psychological well-being and challenges in maintaining relationships in the years after

release from detention. Similarly, Lorek et al. (2009)³⁷ also measured symptoms of anxiety, depression and PTSD however this study focussed on the mental health of children. Qualitative outcome measures involved exploring various aspects of psychological well-being and how they have changed during time in detention. Bosworth & Kellezi (2012)³⁸ combined symptoms of depression and QOL assessed by questionnaire with open-ended questions surrounding conditions inside detention centres.

4.3 QUALITY ASSESSMENT

4.3.1 Quantitative studies

The validity of all eleven quantitative studies included in the review was assessed using the NHLBI quality assessment tool for observational cohort and cross-sectional studies. The full breakdown of the quality assessment is detailed in **appendix 2**.

External validity: The vast majority of studies showed a reasonable level of external validity, with participation rates ranging from 60%³⁹ to 100%²². One study⁴⁰ recorded a response rate that was less than 50% (36%) and Young & Gordon (2016)²⁶ could not measure participation rate due to not knowing the size of the original sample – however it is explained that response rate was likely to be poor. This is important as high participation rates increase the probability that the population under study are more representative of the whole population. Unfortunately none of the included studies chose to use a random sampling strategy across the whole study sample due to the constraints in reaching such a vulnerable population. This severely reduces the generalisability of the findings. Aside from this, sampling strategies generally recruited participants from similar populations within specified time periods and inclusion and exclusion criteria were applied to all participants - with the exception of Bosworth & Kellezi (2012)³⁸ and Heeren et al. (2014).⁴¹ Heeren et al. (2014)⁴¹ recruited different groups of individuals to compare levels of mental distress among asylum-seekers, refugees, labour migrants and Swiss residents. Asylum-seekers were recruited randomly, whereas the other groups were recruited through non-probability sampling – this is likely to have made different subsamples more or less representative of each population being studied.

Internal validity: Internal validity was very low among quantitative studies, especially those that used a cross-sectional study design (n=9). Cross-sectional designs measure exposures at the same time as outcomes and thus do not allow a sufficient period of time to pass for the exposure to cause the outcome. This immediately has implications for the ability to attribute the findings of the study to exposure status. Six studies did however examine evidence of a dose-response relationship between the amount of time spent in detention and

the presence of psychological difficulties in participants - increasing our ability to infer causality between independent and dependent variables in the 3 studies which identified a significant association^{23, 24, 26}.

Overall methodological quality: weak - due to largely cross-sectional study designs and non-random sampling strategies.

4.3.2 Qualitative studies

The quality of all seven qualitative studies (plus the qualitative component of a mixed-methods study) was assessed using the CASP qualitative checklist. The quality of qualitative studies included was generally higher than the quality of quantitative studies - however there are still some uncertainties regarding both the credibility and transferability of the findings.

Credibility: Particular issues affecting the credibility of studies included the lack of information around whether researchers critically examined their own role during the research. In some studies, there is a failure to adequately describe whether measures were taken to minimise potential biases resulting from the researcher-participant relationship³⁰⁻³². Many of the papers do not describe in detail how they went about analysing the data they had collected^{31-34, 36}. It is therefore not possible to comment on whether the analysis process in these papers was appropriate or adequate in extracting themes that accurately represent the data. Credibility was enhanced by member validation during and after interviews and the input of more than multiple researcher in the analysis process – however only two studies mentioned that they took these measures^{29, 33}.

Transferability: Three studies only had extremely small sample sizes which reduces the degree to which the results can be extrapolated to other contexts (n=6:³⁴, n=7:²⁹ and n=9:³¹). The transferability of study findings was also compromised by issues relating to the recruitment strategy. Neale (2012)³¹ only recruited detainees with a reasonable level of English fluency, Puthoopparambil et al. (2015b)³⁰ selected only the detainees that were seen in communal areas of the detention centres, and four other authors' only recruited detainees who specifically had links with their organisations^{32-34, 36}. This is likely to have introduced some selection bias into the sample.

Overall methodological quality: reasonable – however there are some serious flaws in extrapolating the findings of these studies to other populations.

4.3.3 Mixed-methods studies

Both mixed-methods studies did not take into consideration the role of the researcher in the data collection and analysis of the qualitative components. Aside from this, both qualitative components showed a good level of methodological quality. The quantitative components

are of low quality partly because the results are unlikely to be generalisable to the whole population under study due to the small sample sizes used by both teams of researchers. In addition to this, half of the study sample in Coffey et al. (2010)³⁵ decided not to take part – however, this is likely to have understated the influence of detention on mental health and well-being after release from detention.

Overall methodological quality: reasonable – small sample sizes reduce the generalisability of the quantitative components however.

4.4 EFFECTS OF DETENTION

4.4.1 Globally

Six key themes were identified from the results of studies included in this section:

Poor/deteriorating mental health: All of the included studies report poor levels of psychological health and well-being among the detained population. The psychological QOL scores of detainees are particularly low in comparison to physical and social domains of QOL [41.9 vs 47.0 vs 60.5 (out of 100)].²⁵ Evidence for the high prevalence of psychological difficulties in children⁴² and symptoms of anxiety, depression, and PTSD in detained or previously-detained adults was observed in a number of studies^{26, 27, 40-43}. Steel et al. (2011)²⁷ also observed that there were significant differences [$p < 0.001$] between the mental health of migrants who had a history of detention compared to migrants granted permanent protection visas (PPV's) prior to entering the country. Those who had been held in detention showed a deterioration in symptoms of psychological distress compared to the improvement made by those granted PPV's [$p < 0.001$]. This finding was mirrored by Heeren et al. (2014)⁴¹ who found that symptoms of depression [$p < 0.001$] and PTSD [$p < 0.001$] were much higher in currently-detained asylum-seekers than those who had never been detained. Campbell & Steel (2015)²⁹ reported that all detainees ($n=7$) not only described detention in relation to some aspect of depression and distress, but had also observed self-harm and suicidal behaviour whilst in detention.

Conditions and environments of detention on mental health: Overall, the results show that specific conditions of detention were found to exacerbate the mental health and well-being of detainees in particular. Puthoopparambil et al. (2015a)²⁵ found that psychological QOL scores were significantly associated with the levels of support detainees ($n=127$) received from detention staff [$p < 0.01$]. Kronick et al (2015)²⁸ identified that family separation associated with detention contributes to the destruction of children's well-being. The intimidating nature of the detention environment also leaves children feeling criminalised and fearful. Puthoopparambil et al. (2015b)³⁰ reported detainee's accounts of the stressful living

conditions in detention, marked by threatening behaviour from staff, poor living conditions and the lack of adequate mental health support systems in place to cope with stress.

Duration of detention: Those detained for a longer period of time were significantly more likely to experience new mental health complaints or be diagnosed with a new mental illness [$P = 0.018$] – with 27% [95% CI, 27.3%–27.7%] and 39% [95% CI, 38.4%–38.9%] of individuals detained for longer than 24 months receiving a mental health diagnosis or experiencing new mental health complaints respectively.²³ Nielsen et al (2008)⁴² noticed a similar association as children detained for over 12 months had a 5.5 times greater odds [95% CI 1.8–16.3] of experiencing mental difficulties. Length of stay in detention was also a significant predictor of both psychiatric [$P < 0.0001$] and somatic [$P < 0.0001$] diagnoses in adults.²⁴ In another study, symptoms of depression were predicted by time in detention - depression scores were 0.036 points higher per week spent in detention [$P < 0.0001$].²⁶ Despite this, Schwarz-Nielsen & Elklitt (2009)⁴⁰ found no statistically significant relationship between duration of detention and symptoms of anxiety, depression and PTSD.

Number of relocations: There is evidence that number of relocations is associated with increased mental distress among detainees. Goosen et al. (2013)²² found that more than one relocation per year was associated with an increased incidence of diagnosed mental distress in children [Risk ratio = 2.70; 95% CI 2.30–3.17]. In another study, children experiencing four or more relocations in total had an increased risk of psychological difficulty [OR = 3.0, 95% CI 1.4–6.7].⁴²

Emotional and behavioural responses: The experience of detention appears to elicit several negative emotional and behavioural responses among both adults and children. In one study all detainees ($n=7$) described feelings of frustration, stress, hopelessness, and loss of dignity as a result of living in detention centres.²⁹ This hopelessness was mirrored in a qualitative study by Puthoopparambil et al. (2015b),³⁰ where detainees ($n=22$) described a lack of control over their own lives and subsequently a sense of giving up. Kronick et al. (2015)²⁸ reported that children's behavioural and emotional responses to family separation highlights this shattered sense of well-being.

Ongoing difficulties after release: The impact of detention remains with individuals even after being released in the community. Steel et al (2011)²⁷ reported that even upon release from detention, individuals with a history of detention now living in the community on temporary protection visa's (TPV's) were significantly more likely to engage in negative coping strategies such as withdrawal and solitude in comparison to those with PPV's – who coped via social engagement. Stress levels were noticeably higher in TPV holders compared to PPV holders, even months after release from detention [$P < 0.001$]. The experience of

detention remained with individuals trying to rebuild their lives upon release into the community.³⁵ Former-detainees (n=17) struggle with insecurity, negative views of the self, persistent anxiety, depression and demoralisation, and disturbances to their concentration and memory. Coffey et al. (2010)³⁵ also describe the difficulties detainees still experienced in trying to maintain relationships post-release. 88%, 76%, and 70% of detainees scored above cut-off scores for symptoms of depression, anxiety, and PTSD respectively.

4.4.2 In the UK

Five key themes were identified from the results of studies included in this section:

Poor/deteriorating mental health: Overall, studies reported worryingly low levels of psychological health and well-being amount detainees. Lorek et al (2009)³⁷ reported that all children included in the study (n=11) had started to display symptoms of depression and anxiety since being detained. None of the older children (n=6) scored within normal ranges for depression and 5 scored high enough for a diagnosis of clinical depression. Four children scored high enough for diagnosis of a range of anxiety-related conditions. Robjant et al. (2009)³⁹ found that detained asylum-seekers (n=67) were more depressed [$P < 0.001$], anxious [$P = 0.02$], and had higher scores for symptoms of PTSD [$P < 0.05$] than controls living in the community. Similarly, 82.9% of the 131 detainees at 3 UK detention centres had very high levels of depression-associated symptoms.³⁸ Accounts from detainees describing poor mental health are presented by Neale (2012),³¹ Phelps et al. (2009),³³ and Connelly et al. (2015)³⁶ – many detainees spoke about the onset of depression, suicidal thoughts and instances where they have self-harmed or attempted suicide since they had entered detention. Campbell et al. (2011)³² discovered that both parents and their children suffered in detention. Parents reported a decline in their own well-being while in detention and some a worsening of pre-existing mental health problems – parents also commented that their children felt extremely anxious and distressed.

Conditions and environments of detention on mental health: All studies identified a relationship between the environment of detention in the UK and detainees' level of psychological well-being. Individuals felt less depressed, distressed, and isolated if they were treated more humanely and respectfully; believed that the staff were honest and trusted immigration staff; were updated about their asylum case, and if they had better healthcare.³⁸ Brook House detention centre was judged unpleasant and 'prison-like' in the eyes of those detained there.³¹ Detainees commented on the struggle of dealing with separation from their family^{31, 33} and segregation within the IRC. Uncertainty around whether they would ever be released and what would happen to them if they were also contributed to their concern.^{31, 33} Some participants (n=2) stated that the onset of mental illness was simply

a rational response to the conditions in Brook House. Detainees spoke of 'being treated like animals',³⁶ and were affected deeply by witnessing the distress and suffering of other detainees.^{33, 36} Accounts of detainees being held in isolation (n=4) were not uncommon and contributed to high levels of distress.³² This, and families repeatedly not being informed about removal decisions made the experience extremely demeaning. However, Bosworth & Kellezi (2012)³⁸ did report detainees' accounts of positive aspects of life in detention – these included relationships with other detainees (n=31), officers or health care staff (n=13), and the opportunity to practice and reaffirm their religious beliefs (n=28).

Duration of detention: The impact of longer periods spent in detention was pervasive among included studies. For individuals who had experienced interpersonal (IP) trauma in UK detention centres, time in detention did result in higher depression scores [$P = 0.017$].³⁹ Such a profound relationship did not exist between time spent in detention, IP trauma and anxiety scores, however the association did approach significance [$P = 0.056$]. Bosworth & Kellezi (2012)³⁸ also noticed this association as the most severely depressed individuals were more likely to have been in detention for a longer period of time. Qualitative studies also confirmed a worsening of symptoms over a longer period of time.^{31, 36}

Emotional and behavioural responses: There is evidence to suggest that detention causes profound changes in emotional resources and behavioural responses. In comparison to asylum-seekers living in the community, detained asylum-seekers are considerably more likely to use avoidance strategies to cope with negative events [$P < 0.01$].³⁹ There was an overwhelming feeling of confusion, anger, and frustration amongst detainees (n=9) within the UK³¹ - individuals (n=9) described several behavioural and somatic symptoms that had manifested since their time in detention. Campbell et al. (2011)³² found that children had developed behavioural problems since being detained and as above, attributed difficulties sleeping on the frequent nightmares and bed-wetting that began while in detention. Most detainees felt a sense of powerlessness and a lack of control over their own lives and subsequently, many detainees described their future with complete despair – using terms such as 'gone' or 'empty'.³³

Ongoing difficulties after release: The negative impacts of detention did not disappear once individuals were released from detention in the UK. Klein & Williams (2012)³⁴ described the feelings of bewilderment experienced by individuals (n=6) upon their release from detention. Individuals could not understand the reasons behind the decision to deprive them of their freedom and commented on the constraints and restrictions that put in place to enforce this even post-release. Individuals commented on how the period of detention had broken their ties to social networks after many of them had become institutionalised. In a number of

children, the anxiety, distress, difficulties sleeping, frequent nightmares, bed-wetting and behavioural problems listed by Campbell et al. (2011)³² persisted even after release.

5 DISCUSSION

5.1 SUMMARY OF RESULTS

A total of 22 studies were included in this review of the literature, which focussed on the mental health implications of immigration detention. This review is the first of its kind to evaluate findings from a global perspective in the hope that the experience of detainees captured in this review can be applied to detainees across the world and in the UK.

5.1.1 Poor/deteriorating mental health

There is consensus among the included studies that there is an association between immigration detention and poor mental health. This association is observed across all studies regardless of study design and across all regions included in this review. Poor mental health was observed in both children and adults who have been detained and was pervasive across studies that measured mental health in individuals experiencing brief, long-term, and indefinite periods of detention. Symptoms of depression, anxiety, and PTSD were observed in all studies that measured these outcomes - these findings are strengthened by associations found in studies that used clinical observation to diagnose mental health issues³⁷ and objective outcome measurements^{23, 24} such as mental health issues through analysis of ICDPC codes.²² Quasi-experimental studies that incorporated comparison groups within their design also reported the association between detention and symptoms of depression, anxiety, and PTSD.^{27, 39, 41} In all of these studies, participants who had never experienced detention showed noticeably lower levels of depression, anxiety and PTSD. This suggests that the poor mental health experienced by detainees is in some part attributable to the detention process, and that background mental health issues associated with previous trauma does not fully explain the extent of the findings. The inclusion of qualitative studies in this review has also added to the strength of evidence behind these observed associations by accessing personal accounts that would normally not be divulged in a questionnaire. The accounts of detainees all describe the onset or deterioration of depressive thoughts and symptoms of anxiety as a result of the detention experience. Poor mental health in detention centres is highlighted by accounts of both experiencing and witnessing self-harm and suicidal behaviours, with some individuals recalling personal suicide attempts.

5.1.2 Conditions and environments of detention

Another important objective of the review was to examine which parts of the detention experience influence the mental health of detainees most and in what way do they impact their well-being. There is evidence to suggest that the physical environment of detention

centres and the relationship between detainees and immigration staff both play an important role in the well-being of those detained there,^{25, 38} both inside the UK and globally. Detention often results in the separation of families. The qualitative research included in this review has shown that this separation causes significant distress among those members of family who are detained – this was a common theme among both children²⁸ and adults.^{31, 33} In separate studies, detention centres were described as ‘intimidating’ and ‘prison-like’ and from detainees’ accounts of detention, examples emerged of being treated poorly and unfairly by immigration staff – these contributed to the ongoing distress of detainees. The poor treatment of detainees was underlined by accounts of detainees being held in isolation,³² experiencing threatening behaviour from immigration staff³⁰ and receiving inadequate support for mental health issues.^{30, 36} There seems to be a pervasive lack of communication between immigration staff and detainees surrounding bail and release procedures.³² Detainees commonly spoke of the uncertainty that accompanies the lack of information about when and if they will be released,³¹ and told of the distress and confusion that the unspecified length of detention creates.^{31, 33} When asked about positive aspects of life in UK IRC’s, some detainees did state that relationships with other detainees and staff were good, however a far greater proportion reported that there was nothing positive about life in detention.³⁸ This research shows that there are systemic issues with the level of care received by detainees while in detention. While some of these accounts may have been exaggerated by detainees, it is unlikely as participants were told that responses would not affect their chances of release and that all accounts would remain anonymous. These findings help us to understand some of the mediators of the relationship between detention and poor mental health.

5.1.3 Duration of detention

Longitudinal study designs and cross-sectional studies that collected data on the total time spent in detention allow us to postulate theories about whether those who spend longer in detention experience more severe or more frequent mental health issues as a result. On the whole, this review provides evidence of an association between duration spent in detention and a worsening of mental health both in the UK and globally. Although only eight studies measured the impact of duration in detention on mental health, only one did not find a significant association.⁴⁰ Symptoms of depression^{26, 38, 39, 42} and mental difficulties⁴² were predicted by time spent in detention, and the increase in the incidence of mental health diagnoses^{23, 24} in detainees spending longer in detention provides stronger evidence that this association may exist. The results from qualitative studies also support these findings. One study did not find an association between time in detention and symptoms of depression, anxiety and PTSD.⁴⁰ However, there are methodological issues in this study that raise

questions for the representativeness of the study sample. Bosworth & Kellezi (2012)³⁸ did not have access to reliable time spent in detention data – therefore responses from detainees could not be verified. Further research must be undertaken, preferably using a longitudinal design and objective outcome measures, to establish whether the relationship between time spent in detention and poorer mental health outcomes is causal. Despite this, these findings have serious implications for UK detention policy which continues to incarcerate individuals for unacceptable and often indefinite periods of time. Although brief detention has immediate implications for the mental health of detainees, these findings show that those detained at length are noticeably more likely to experience severe mental health difficulties.

5.1.4 Number of relocations

Although scanty, research undertaken in Denmark and The Netherlands has identified the significance that the resettling process has on the mental health of adults and children in detention. In these included studies, numerous relocations between detention centres is shown to be detrimental to mental health outcomes with reported increases in newly diagnosed mental distress²² and psychological difficulty.⁴² Although these results cannot reliably be generalised to the UK context, it is difficult to understand why these findings would not be observed within the UK, as the relocation of detainees is still a common practice.

5.1.5 Emotional and behavioural responses

This review demonstrates that the pathway from detention to poor mental health is multifaceted, with several mediators and sequelae that transpire as a result. Among many others, a particularly common emotion observed consistently among detainees' regardless of population is the feeling of 'powerlessness' or 'helplessness' that contributes to poor mental health.^{28-30, 33} The process of detention takes away individuals' sense of control and autonomy over their own lives and subsequently forces detainees into passivity. It is therefore not surprising that many individuals described how they had given up as a result, and that their perceptions of what the future held were bleak. Behavioural responses to the detention environment were observed, especially in young children. Mood changes were common, with children crying more often and developing signs of aggressivity while in detention.²⁸ The qualitative papers suggest that a large proportion of children develop difficulties sleeping and commonly experience nightmares and episodes of bed-wetting.^{28, 32} This review shows that detention is a frightening experience for children in particular which is typified by these physiological responses to stress. Quantitative research included here shows that adults too exhibit changes to their behaviour as a result of detention, with

detained asylum-seekers responding more negatively to stressful experiences than their counterparts living in the community.³⁹

5.1.6 Ongoing difficulties after release

On release from detention, many of the mental health issues and behavioural responses outlined above persist in both adults and children for many years – possibly indefinitely. Much of the qualitative research shows that former detainees were still troubled by events that happened whilst in detention. The period of detention severely impacted individuals' ability to maintain relationships, to integrate, to deal positively with stressful events, and to feel accepted by the community. Symptoms of depression, anxiety, and PTSD remained high in former detainees after almost four years of living outside of detention.³⁵ However, difficulties experienced post-release may partly be explained by the restrictive policies imposed by the UK government on former detainees, which was shown to contribute detainees' sense of autonomy.³⁴ Likewise in one included study,²⁷ poorer mental health outcomes post-release may be partly explained by the temporary nature of their visa status. Further research is needed to establish the extent to which restrictive policies impact mental health outcomes in comparison to the detention process itself. However, the findings of this review do support the belief that detention has an independent, longstanding influence on the well-being of former detainees.

5.2 CONCEPTUAL MODEL

5.2.1 Pathways and mediators of harm

The findings of the narrative synthesis provide an opportunity to outline the potential pathways by which the detention experience influences mental health outcomes among detainees.

Figure 2 – Pathways and mediators of harm

5.3 COMPARISONS TO PREVIOUS RESEARCH

The findings of this paper add to the relatively scarce amount of research undertaken prior to this review. In their systematic review, Robjant et al. (2009b)¹⁷ reported that all ten papers included found a consistent relationship between detention and poor mental health. Specific markers of poor mental health observed in these studies, namely symptoms of depression, anxiety, PTSD⁴⁴⁻⁴⁶ and suicidal ideation⁴⁶⁻⁴⁸ were all common in the current review.

Qualitative research has explored some of the main mediators of the relationship between detention and poor mental health which was highlighted by Robjant et al. (2009b)¹⁷ as an area for further research. Specific components of the detention environment including separation, isolation, and poor treatment by immigration staff were all found to contribute to poor mental health. These findings further our understanding about how detention brings

about changes in mental health. This results of this review mirror the results of previous studies that have measured the impact of longer periods of detention on mental health outcomes^{44, 49, 50} – with longer periods of detention consistently associated with poorer mental health. A significant finding of this review concerns the negative impact of numerous relocations between detention centres on detainees' mental health – this had not been discovered in the previous systematic review. Although further research is needed to improve understanding of the associations observed and to examine its influence in different regions of the world, these preliminary results open up a new potential aspect as to why the detention experience is so damaging to detainees. Similar patterns of emotional and behavioural responses to detention emerged from the current review. Studies targeting individuals who have been released from detention have shown that the experience of detention does have an independent effect on post-release mental health outcomes^{28, 34, 35, 39} – this helps to disentangle the relationship described by Robjant et al. (2009b)¹⁷ in determining whether post-release outcomes were merely a result of restrictive post-release immigration policies.

5.4 LIMITATIONS

5.4.1 Limitations of included studies

Studies included were of a variable methodological quality (**appendices 2 & 3**). The majority of studies were cross-sectional in nature and therefore this has major implications for the internal validity of the findings. There therefore may be alternative explanations for the results observed in these studies. The extreme logistical and political difficulty in accessing this population for inclusion in the studies contributed to other methodological issues. Because of this, small sample sizes were recruited for many of the studies and random sampling strategies could not be used in most studies. This, along with the fact that the conditions of detention vary between detention centres and between countries, limits the generalisability of the results. The fact that many studies approached detainees through links with support organisations also raises issues with the representativeness of the study sample, as only those known to them could be included in the study. Therefore those least affected by mental health issues and those with the most severe mental health issues may have been excluded. Studies that have used self-report measures are often prone to misreporting, both intentionally and unintentionally. Misreporting is especially common when participants are asked about symptoms and experiences that are retrospective – however included studies did attempt to minimise levels of over reporting of symptoms by explaining that accounts would not affect their chances of release. Due to a variety of cultural differences and languages spoken included in the study, it is possible that inaccuracies

occurred in the measurement of symptoms and experiences of detention. In most studies however, questionnaires and protocols were translated and back-translated into the relevant languages and interpreters were on hand to assist with any further translation issues. In a few studies, attempts were made to involve researchers with experience of working with migrant populations in order to minimise the influence that cultural barriers had in the data collection process. Finally, although using control groups and performing statistical analyses has helped to isolate the independent impact of detention on mental health, alternative explanations for observed associations may still exist as some key potential confounders were not able to be measured in the included studies, these include the exact impact of pre-migration trauma and the consequences of other post-migratory restrictive policies.

5.4.2 Limitations of review

For practical ease, only studies published in English were included in this review. It is therefore likely that important research published in other languages has been missed by this review. It is also likely that grey literature published by lesser-known organisations was not captured by the search strategy. Due to time restrictions, the number of databases searched was truncated in order to complete the review by the desired deadline. This review was undertaken by one author. Although studies were assessed using validated tools designed to increase the objectivity of assessing their quality, the potential for researcher bias during this procedure is fairly high. The presence of another researcher would have provided a second opinion on borderline decisions and may have heightened overall impartiality in this process.

6 RECOMMENDATIONS

6.1 RECOMMENDATIONS FOR POLICY

- ❖ Due to the damaging effects of even brief detention, detaining individuals as a policy must be used only once all other options are exhausted. Governments should look into the possibility of using alternatives to detention.
- ❖ The UK is one of the few countries that does not have a time limit on detention. The UK government must end the indefinite detention of individuals.
- ❖ Individuals with severe mental health issues or previous experiences of trauma should not be detained - detention centres are stressful environments and support services provided are inadequate in maintaining the mental health of detainees.
- ❖ More must be done to avoid the separation of families, especially where young children are involved. Alternatives to detention such as case management programmes that take place in the community should be used in these instances.
- ❖ Children should never be detained. The trajectory of their development at such a critical stage in their life is likely to be severely curtailed by the experience of detention.
- ❖ Governments should avoid the unnecessary relocation of detainees between detention centres.
- ❖ Regular inspections of the level of care provided in detention centres must be introduced in order to promote staff-detainee relationships. Staff should receive training on how to provide adequate levels of care and increased communication surrounding bail procedures should be encouraged.

6.2 RECOMMENDATIONS FOR FURTHER RESEARCH

- ❖ Greater access to detainees must be afforded to improve the representativeness of study samples used. This will assist in producing studies with fewer methodological weaknesses.
- ❖ Future studies should aim to use longitudinal study designs in order to measure the direct effect of detention over time and to observe changes in mental health that occur independently of other, pre-migration, post-migration and demographic factors.
- ❖ To look at whether the number of relocations experienced by UK detainees is associated with poorer mental health outcomes, as observed in other countries of Europe.
- ❖ To conduct studies that include the perspectives of multiple stakeholders, particularly the views of immigration staff working at detention centres and how they believe conditions of detention influence the mental health of detainees.
- ❖ Future studies must begin evaluate the effectiveness and feasibility of current alternatives to detention. This will provide an evidence-base that governments can use to guide policy decisions.

7 CONCLUSION

Despite the limitations of this paper, this review provides evidence to suggest that an association exists between immigration detention and poor mental health outcomes – this is in agreement with previous research. This review has identified that several aspects of detainees' mental health are severely worsened by the experience of detention, as well as providing some preliminary insights into the mediators of this relationship raised as an area of future research by the authors of the previous review paper ¹⁷. From reviewing recent literature published in the UK, it is evident that many of the same problems faced by detainees across the world also exist in UK immigration detention centres. It is for these reasons that the necessity for further research in this field, although fraught with political and ethical concerns, is urgent and must be permitted. Denying researchers the opportunity to do so raises serious questions about the legitimacy of UK immigration detention practices.

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