Mental health implications of detaining asylum seekers: systematic review

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Background

The number of asylum seekers, refugees and internally displaced people worldwide is rising. Western countries are using increasingly restrictive policies, including the detention of asylum seekers, and there is concern that this is harmful.

Aims

To investigate mental health outcomes among adult, child and adolescent immigration detainees.

Method

A systematic review was conducted of studies investigating the impact of immigration detention on the mental health of children, adolescents and adults, identified by a systematic search of databases and a supplementary manual search of references.

Results

Ten studies were identified. All reported high levels of mental health problems in detainees. Anxiety, depression and post-traumatic stress disorder were commonly reported, as were self-harm and suicidal ideation. Time in detention was positively associated with severity of distress. There is evidence for an initial improvement in mental health occurring subsequent to release, although longitudinal results have shown that the negative impact of detention persists.

Conclusions

This area of research is in its infancy and studies are limited by methodological constraints. Findings consistently report high levels of mental health problems among detainees. There is some evidence to suggest an independent adverse effect of detention on mental health.

Declaration of interest

None.

The number of asylum seekers, refugees and internally displaced people worldwide rose to 20.8 million at the beginning of 2006. Western countries have increasingly resorted to policies aimed at reducing the numbers of individuals seeking residency. These ‘policies of deterrence’ include the reduction of access to healthcare services, education and employment as well as an increase in the practice of detaining individuals who are seeking asylum and the provision of time-limited rather than permanent protection. Immigration removal centres in the UK are secure environments where asylum seekers and other categories of foreign nationals are detained. Individuals are held within these centres for an indefinite period while awaiting the outcome of administrative processes regarding their application for leave to remain in the UK. The majority are deemed by the Home Office to have exhausted their legal processes and to be ‘failed asylum seekers’ awaiting removal to their country of origin or to a third country. Some, however, are still in the process of legal appeal and others initiate fresh asylum claims while in detention. Another group that may be detained in these centres are foreign nationals who have completed prison sentences for offences committed in the UK and are awaiting or contesting deportation. Within the UK there is a capacity of 2557 places for immigration detainees and deportees. In 2005, a total of 29 210 individuals left detention. Of these, 59% were deported from the UK. The rest were given temporary leave to remain or were granted bail to live within the community until the outcome of their claim was determined.

Under the 1951 United Nations Convention on the Status of Refugees, a refugee is an individual who has successfully completed the legal processes required to achieve permanent residency within the host country. Refugees are therefore not detained in immigration removal centres. Asylum seekers are entitled to recognition as a refugee if they have a well-founded fear of persecution because of race, religion, nationality, membership of a social group or political opinion. Asylum seekers have often experienced traumatic events in their country of origin. Individuals detained within immigration removal centres could, therefore, be described as a vulnerable group particularly susceptible to the adverse effects on mental health associated with detention. According to Home Office guidelines, individuals who are experiencing mental health problems should not be detained unless there are exceptional circumstances.

Mental health of asylum seekers

Research suggests that asylum seekers and displaced persons worldwide report high rates of pre-migration trauma, and therefore of trauma-related mental health problems. In a meta-analysis of worldwide studies investigating the mental health of refugees (including asylum seekers and displaced persons), Porter & Haslam found high rates of psychopathological disorder among refugees worldwide compared with non-refugee control groups. There is therefore consistent evidence to suggest that asylum seekers and refugees have higher rates of mental health difficulties than are usually found within the general population. The process of seeking asylum in Western countries places additional demands on this group. These include stressful legal processes. In an Australian study comparing post-migratory stress in refugees, asylum seekers and immigrants, Silove et al showed that the ‘refugee determination process’ (including interviews by immigration officials) was regarded as stressful by asylum seekers.

In addition, a Dutch study showed that longer asylum processes result in increased risk of psychiatric disorder. The authors also reported increased anxiety, depression and somatoform disorders in individuals who had lived in The Netherlands for more than 2 years compared with refugees who had arrived within the preceding 6 months. Consistent with these findings was the observation of high rates of post-traumatic stress disorder (PTSD) symptoms in both groups. Post-migratory stressors seem, therefore, to be negatively affecting this population, who are already vulnerable to mental health difficulties as a result of their previous exposure to traumatic events.
Asylum seekers in detention

Asylum seekers who are detained in the host country experience a further and more specific set of stressors, reflecting the detention process itself and the detention centre environment, which may adversely affect their mental health status. These include loss of liberty, uncertainty regarding return to country of origin, social isolation, abuse from staff, riots, forceful removal, hunger strikes and self-harm.\(^5\)\(^\text{-}^1\) Given the well-documented vulnerability of asylum seekers as a result of experience of trauma prior to arrival, a number of clinicians have expressed concern that detention increases mental health difficulties in adult and child asylum seekers, and have called for an end to such practices.\(^1\)\(^\text{-}^3\) This conflicts with current government policy aimed at reducing numbers of asylum seekers.\(^4\) The practice of detaining asylum seekers is therefore currently a prominent and contentious issue in terms of policy, health and social care. These issues are outlined in more depth by Steel & Silove.\(^4\)

The aim of this review was to identify studies that have investigated the impact of immigration detention on the mental health of detainees held in Australia, the UK and the USA. Studies that investigated the impact of detention on children and adolescents were included in the review. The results of these studies were reviewed in order to consider whether there is evidence for an association between increased prevalence and severity of mental health problems and immigration detention.

**Method**

**Search strategy**

The search terms 'asylum', 'detention', 'depression', 'anxiety' and 'PTSD' were used to identify relevant studies in the databases PsycINFO, PubMed, PubCentral and PILOTS, with a cut-off date of April 2007. In addition, manual searches of the reference lists of relevant studies were used to identify further relevant studies.

**Inclusion criteria**

We included all studies that reported quantitative or qualitative measures of mental health for children, adolescents or adults who were either currently detained or who had previously been detained in immigration detention or removal centres in Australia, the UK or the USA. Qualitative studies that described consecutive case series of more than two cases were included.

**Exclusion criteria**

Single-case studies were excluded. The search strategy outlined above yielded several commentaries and letters, which were also excluded, as were review papers, although relevant studies identified from the references cited within these commentaries were included. Studies conducted in other countries were excluded.

**Selected studies**

The above search strategy was carried out by the first author (K.R.) and resulted in the identification of 49 articles (including studies that met the inclusion criteria as well as commentaries, letters, case studies and studies that took a legal or sociological stance). Uncertainties about whether individual studies met the inclusion criteria were resolved by discussion between the authors. This selection process resulted in ten studies being identified for detailed review.

**Results**

Studies that met the selection criteria can be grouped into those reporting on case series and those comparing currently or formerly detained asylum seekers with a comparison group. The design, measures, results and findings are summarised in Table DS1.

**Case series**

Bracken & Gorst-Unsworth and Arnold et al have both described opportunistic case series of asylum detainees in the UK.\(^15\)\(^\text{-}^16\) They described therapeutic and assessment work undertaken by clinicians within organisations working with refugees and asylum seekers: the Medical Foundation for the Care of Victims of Torture (www.torturecare.org.uk) and Medical Justice (www.medicaljustice.org.uk). Although the studies took place 15 years apart, both describe manifest psychological or psychiatric difficulties experienced by detainees with whom the authors had worked. Bracken & Gorst-Unsworth described the evidence leading to their clinical conclusion that there was a high level of psychological disturbance and a consistent pattern of symptoms in each of ten detainees, all of whom had previously experienced torture.\(^15\) This included intense fear and anxiety, sleep disturbance and nightmares, irritability and frustration, as well as profound hopelessness and concerns about their own mental health. The authors did not report the use of any standardised ratings, which compromises the validity of their results. They described six of the individuals as expressing anxiety regarding their mental health, and all ten reporting depressed mood, appetite loss and other physical problems. Four detainees had suicidal ideation, two of whom had made actual suicide attempts. Although these qualitative impressions are useful in indicating emotional problems experienced by detained persons, a detailed case study is provided for only one individual and the extent to which these experiences are generalisable to other detainees is not addressed.

More recently, Arnold et al reported the results of the medical assessment of 56 consecutive patients who were either in detention or had been recently released: 59% fulfilled ICD–10 criteria for PTSD or depression.\(^16\) Adherence to a specified diagnostic tool increases the validity of these findings but it is unclear how representative their sample is of the asylum detention population as a whole. These reports of high levels of mental health problems among detainees are consistent with a participant–observer account reported by Sultan & O’Sullivan, an Iraqi doctor who had been detained in an Australian immigration centre and a clinical psychologist working at the same facility.\(^17\) These authors suggested that psychological difficulties observed among detainees increase through successive stages, triggered by negative outcomes on asylum decisions. Their descriptive reports are supported by a survey of 33 detainees (predominantly men), using a semi-structured interview.\(^17\) Individuals who had been detained for over 9 months were invited to participate; the findings represent 89% of this target population and are therefore highly representative of this subsample of detainees. Among those interviewed, 85% reported chronic depressive symptoms, 65% reported suicidal ideation, 39% were experiencing paranoid delusions and 21% showed signs of psychosis. In addition, 57% of participants required psychotropic medication. Information regarding the nature of the measures used to rate symptoms was not provided.

The findings from these case series provide clear documentary evidence of serious mental health problems among detainees. However, as collections of case studies they are subject to selection bias.
and may not be representative of detainees, many of whom do not come into contact with these specialist organisations. In addition, the association between detention experience and poor mental health is confounded by high rates of previous trauma exposure in the detainees studied. The extent to which detention can be described as having an independent negative impact on mental health is therefore not fully clarified by these reports. However, the high rate of disorder reported compared with the general refugee literature and the description of increasing symptom severity with increasing time in detention at least suggest an independent or confounding role for the detention process.27

Systematic studies

More systematic methods were used in a small number of studies, mainly carried out in Australia. Thompson et al compared a group of 25 detained Tamil asylum seekers from Sri Lanka with a community-based group of Tamil asylum seekers.18 They also compared findings with those in non-detained refugees and migrants from the same ethnic background. The comparison group data came from a previous study in which levels of trauma and symptoms had been investigated.19 The authors used self-report measures commonly applied in research with asylum seekers and refugees: the Harvard Trauma Questionnaire,20 the Depression, Anxiety and Somatisation scales of the Hopkins Symptom Checklist–25,21 as well as the Four Measures of Mental Health Panic Scale,22 and a measure of exposure to post-migration stressors designed for the study. Respondents in the detainees group were more depressed and suicidal, and experienced more extreme post-traumatic panic and anxiety as well as increased somatic distress. An additional important finding was that detained participants had been exposed to a greater number of trauma experiences. However, levels of pre-migration trauma did not account entirely for the differences. The authors concluded that this suggests that the conditions of detention also contributed to the mental health difficulties experienced by detainees. Although the descriptive data are useful in demonstrating that detention was associated with increased incidence of mental health difficulties on all measures, it is difficult to draw conclusions from this in the absence of any details regarding the statistical techniques used or the results of multivariate analyses.

In a study based on a population of Mandaean refugees in Australia, Steel et al found further evidence for a relationship between detention and mental health problems.23 Using snowball sampling techniques, the authors recruited 241 participants (constituting an estimated 60% of the Mandaean refugee population living in Sydney) and assessed the prevalence of PTSD and of major depressive disorder as well as stress factors which were related to past trauma, detention and temporary protection. Clinical measures included the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist–25. The mental and physical health component summaries of the Medical Outcomes Study – Short Form were used to measure mental and physical health status and disability.24 The authors used the Detention Symptom Checklist to assess adverse effects of particular experiences associated with detention.25 The authors also compared the effects of being granted a temporary protection visa v. a permanent protection visa. Temporary protection is a less secure status, specifically adapted for detention experiences increases the validity of findings. Administration of interviews through one native Persian speaker maximised transcultural validity.26 The use of snowball sampling techniques resulted in recruitment of a large proportion of the target populations,23 although as the authors of the study acknowledge, it is possible that more distressed individuals were more likely to participate. Studies that have targeted a specific group are useful in allowing within-group comparisons and in increasing the number of populations in which these issues have

Using multivariate analyses, the authors investigated whether there was an independent effect of detention and of temporary v. permanent protection visa status. Time in immigration detention and temporary protection contributed independently to all three measures of mental health difficulties (P < 0.05), even when other significant risk factors such as trauma history, family composition, age, gender and length of residency were taken into account.

Additional univariate analyses within the group who had experienced detention showed greater levels of traumatic distress related specifically to past detention among those who had been detained for longer than 6 months compared with those who had been detained for shorter periods. A higher proportion of those who had been detained in excess of 6 months met diagnostic cut-offs for PTSD, depression and moderate to severe mental health-related disability than those who had been detained for shorter periods or who had not been detained. A parallel study by the same group investigated the same factors in Persian-speaking refugees.26 All former detainees rated detention experiences as causing serious or very serious stress. These included fears of being sent home, being told they should return home by officers in detention facilities and language difficulties (reported as causing serious or very serious stress by 95%). In this study, 42% of participants had temporary protection visa (TPV) status and 58% held permanent protection visas (PPVs). Temporary protection visa status included previous experience of detention for an average of 1 year, whereas holders of a PPV had not experienced detention. Univariate analyses using two-sample t-tests showed significantly higher scores in TPV holders compared with PPV holders on anxiety (P < 0.001), depression (P < 0.001), PTSD (P < 0.001) and general distress (P < 0.003) (as measured by the General Health Questionnaire27). These differences were not attributable to experience of pre-migration trauma.

Again, multivariate analyses were used to test whether post-migration factors had an independent adverse effect. Holding a TPV was the most significant predictor of PTSD. In order to explore further the negative impact of post-migration stress, the number of negative detention experiences, the number of current living difficulties and current separation from spouse replaced TPV status in a second multivariate model, as the combination of these stressors were shown to have ‘almost perfect collinearity’ with TPV status. This second model was used to analyse the independent effects of these stressors on measures of mental health and disability, while adjusting for the effects of age, gender and pre-migration trauma experiences. Of particular interest in this review is the independent impact of detention. Past detention stressors predicted PTSD (β = 0.47, P < 0.001) and mental health-related disability (β = 0.30, P < 0.001), but did not predict anxiety, depression, general distress and physical health-related disability.

These studies are the first to investigate the mental health implications of detention followed by temporary compared with permanent protection. They suggest that the combination of the detention experience and continued immigration status uncertainty following release is particularly harmful to mental health. The study by Steel et al shows that the damaging effects of detention persist following release.23 The use of measures that have been used widely in refugee research in addition to measures specifically adapted for detention experiences increases the validity of findings. Administration of interviews through one native Persian speaker maximised transcultural validity.26 The use of snowball sampling techniques resulted in recruitment of a large proportion of the target populations,23 although as the authors of the study acknowledge, it is possible that more distressed individuals were more likely to participate. Studies that have targeted a specific group are useful in allowing within-group comparisons and in increasing the number of populations in which these issues have
been addressed, although the findings from any one study may not
generalise to other refugee groups from different backgrounds.

In the only longitudinal study we identified, Keller et al looked
at rates of symptoms of depression, anxiety and PTSD in detained
asylum seekers and compared them with rates of mental disorder
at follow-up.26 Initial baseline interviews were conducted with 70
detainees (73% of those eligible) with a median duration of
detention of 5 months. Follow-up data were collected at a median of
101 days later in 61 of the original participants. Some
participants had been released (n=26) but the rest were still in
detention. The authors used the PTSD sub-scale of the Harvard
Trauma Questionnaire and the Hopkins Symptom Checklist–25
to measure anxiety and depression. Spearman correlation
coefficients were used to examine the relationship between time
in detention and anxiety (r=0.34, P=0.004), depression (r=0.28,
P=0.017) and PTSD symptoms (r=0.28, P=0.019). Consistent with
findings in the Australian studies,23 time in detention was directly
related to severity of symptoms. This was also consistent with
subjective reports; 70% of detainees reported deterioration in their
mental health while in detention. Overall, clinically significant
levels of depression, anxiety and PTSD were found in a high
proportion of detainees in the sample (86%, 77% and 50% respectively).
Independent sample t-tests were used to compare symptom scores from baseline at follow-up in those who had been
released and those who were still detained. At baseline there was
no significant difference between group scores in those who were
eventually released and those who were still detained. The difference at
follow-up was significant; however, reductions in symptoms were
observed at follow-up in those who had been released (P<0.0001). The repeated-measures design allows for measure-
ment of the effect of release from detention in comparison with
continued detention in two groups of detainees who did not
differ at baseline. These studies consistently suggest a possible
independent effect of detention on mental health.

In the first study to investigate the impact of detention within
the UK, Pourgourides et al provide qualitative explanations of
how detention affects people psychologically.9 In-depth interviews
with 15 male former detainees as well as focus group discussions
(comprising former detainees, members of detainee support
and campaigning groups, professional advisors and health
professionals) informed a grounded theory account of how and
why mental health problems arise in this group. The results of
psychiatric diagnostic interviews with the detainees were reported:
27% were diagnosed with PTSD, 60% with depression, 7% with
panic disorder and 7% with psychosis. Detailed qualitative
findings from the study are outlined at length by the authors
but are not described here. The authors highlighted a number of
specific difficulties unique to the detention experience, which
adversely affect mental health. The detention experience
incapacitates detainees, in that it does not allow utilisation of
usual coping skills, and constitutes a meaningless environment.
Detainees are therefore preoccupied by time and experience
extreme boredom and frustration as well as a sense of having no
future. The potential for the detention environment to reactivate
and exacerbate previous traumas was also raised as a theme. The
authors conclude that the high incidence of hopelessness,
depression and despair among detainees can be regarded as
normal reactions to an abnormal situation, and detention itself
as an ongoing trauma.

Impact of detention on children, adolescents
and their families

Three studies that met our inclusion criteria looked at the impact
of detention on children and their families.17,25,28 In addition to
the observations of mental health problems in adults, the
participant–observer study by Sultan & O’Sullivan also reported
on the effects on children.17 These effects were considered to be
mediated through negative characteristics of the detention
environment itself as well as through the impact of detention on
the parents’ mental well-being. Observed disturbances included
separation anxiety, disruptive conduct, nocturnal enuresis, sleep
disturbances (including nightmares, night terrors and sleep-
walking) and impaired cognitive development. Severe symptoms
of distress (including mutism, refusal to eat and drink, and
stereotypical behaviours) were also reported in some cases. These
reflect observations made by the authors, and unfortunately no
information regarding the prevalence of these observations is
reported, severely limiting the reliability of these data.

Mares & Jureidini reported on ten consecutive referrals made
to a child and adolescent mental health service in Australia from a
detention centre.28 The study involved 16 adults and 20 children
who were detained at the time of the study and had been in
detention for 1–2 years at the time of the first interview. The study
also included a follow-up interview for five families at 12 months.
All participants were interviewed by child psychiatrists or allied
health clinicians and consensus diagnoses were made. The authors
reported that all children had at least one parent with mental
health problems, but only two adults reported mental health
difficulties prior to arriving in Australia. Among the 16 adults
within the sample, 87% had major depression, 56% showed
clinical symptoms of PTSD and 25% had a psychotic illness.
Self-harm was also common – 31% had made significant repeated
attempts. Among children aged less than 5 years, developmental
delays were common. Out of ten such children, half had delays in
language and social development. Emotional and behavioural
dysregulation as well as attachment problems were observed.
Among the children in the older age range (6–17 years) mental
health difficulties were extensive. All ten of these children met
clinical criteria for PTSD. In addition, all ten had major
depression and expressed suicidal ideation. Eight children had
actually engaged in self-harm and the authors noted that a culture
of self-harm existed within the detention centre. Seven had
symptoms of anxiety disorder and half had persistent physical
health symptoms. Children regularly reported boredom, a sense
of injustice, sleep difficulties, anxiety regarding delays in
educational progress and a sense of shame.

At the 12-month follow-up the well-being of the five families
who were still detained had deteriorated. The authors reported
that an initial improved sense of well-being among families who
had been released from detention had generally not persisted.
However, neither clinical diagnostic information nor outcomes
from self-report measures accompanied these clinical observations
in the report. In addition, the representativeness of these cases for
other families held within this centre is unclear. The initial severity
of the psychopathological symptoms in these children might have
precipitated the initial referral to the service and their subsequent
inclusion in the study.

Steel et al investigated mental health difficulties among
detained families from a single ethnic group in one centre in
Australia,25 by administering psychiatric interviews by telephone.
The ethnic origin of the detainees interviewed was not specified in
order to protect their anonymity. The study sample consisted of
nearly all the members of the particular ethnic group within a
single detention centre, comprising 10 families (14 adults and
20 children) out of 11 families who were eligible. Participants
had been detained for a minimum of 2 years. All adult participants
stated that they had experienced traumatic events prior to leaving
their country of origin as well as en route to Australia. The semi-
structured interviews included the Structured Clinical Interview
for DSM–IV Axis I Disorders (SCID–IV) for adults and the Schedule for Affective Disorders and Schizophrenia for School-age Children – Present and Lifetime version (K–SADS–PL) for children.\textsuperscript{29,30} These measures allowed assessment of prevalence of psychiatric disorder during detention as well as allowing diagnoses to be made retrospectively for the incidence of mental health difficulties prior to detention. The interviews also consisted of measures of common experiences in detention (Detention Experiences Checklist), as well as a list of nine stress symptoms taken from standard PTSD measures but focused on the detention experience itself (designed for this study): the Detention Symptom Checklist. A parenting questionnaire, again designed for the purpose of the study, was also included. All adults reported pre-migration trauma as well as traumatic experiences occurring in detention.

Psychiatric assessment indicated the prevalence of psychiatric disorders in adults and children to have increased markedly since the participants were detained. All adult participants were diagnosed with major depressive disorder, whereas only 21% reported symptoms (retrospectively) that would indicate a diagnosis of depression prior to detention. Two (14%) were diagnosed in detention with severe depressive disorder with psychotic features. A large proportion (86%) of adults were also diagnosed with PTSD while in detention – 50% of these cases were also retrospectively diagnosed with this. There was also an increase in suicidal ideation, with 93% of adults experiencing persistent suicidal ideation. Prior to detention, none of the participants had experienced persistent suicidal ideation nor had self-harmed; 36% of adults had self-harmed when assessed during detention. Overall, the authors reported a threefold increase in psychiatric problems. Parents also reported a marked decrease in their parenting capabilities since being detained. Only one adult responded positively to being ‘able to care for and support children’ and ‘able to control the behaviour of children’ while detained, whereas all participants stated that they were able to do this prior to detention.

Similarly to the results for parents, a substantial increase in psychiatric disorders was reported at the time of assessment among children. Comparison of the diagnoses made at the time of assessment while children were detained, with retrospective diagnoses for incidence of psychiatric disturbance prior to detention, revealed a tenfold increase in psychiatric difficulties among these children. All children were diagnosed with at least one psychiatric disorder at the time of assessment, the majority (80%) exhibiting multiple disorders. While in detention, 50% of the children were diagnosed with PTSD (with some re-experiencing symptoms being directly related to events in detention), but one child received a diagnosis of major depressive disorder and 50% were diagnosed with separation anxiety disorder. Oppositional defiant disorder was also common, occurring in 45% of cases. Enuresis was present in 20% of the total sample but in four out of seven children aged 6–10 years, the age range in which this disorder usually occurs. Suicidal ideation was reported by 55% of the sample and 25% had self-harmed by cutting their wrists or head banging. In contrast, prior to detention, only one child met criteria for multiple disorders (depression, PTSD and separation anxiety). Two other children were retrospectively diagnosed with either depression or separation anxiety prior to being detained.

In addition to these findings of a deterioration in mental health during detention, the use of the Detention Experiences Checklist and the Detention Symptom Checklist allowed analysis of the extent to which current difficulties were directly linked to detention experiences. All participants reported experiences of traumatic events occurring during detention. ‘Sudden and upsetting memories of the time in detention’ and ‘images of threatening or humiliating events in detention’ were reported as causing distress in all adults and in 90% of the children. Increased anger and ‘feeling extremely sad and hopeless’ were also reported by all adults. All of the other nine detention-related symptoms were reported as causing distress in 86–100% of adults and in 53–90% of children. Although this study is limited by the methodological problems associated with administering interviews by telephone and the possibility of recall bias, the findings suggest an overall deterioration occurring as a response both to the detention process itself and to specific detention experiences.

Discussion

Findings from these studies consistently support an association between the experience of immigration detention practices and poor mental health. This association has been demonstrated using a variety of research methods with individuals detained in varying contexts in the UK, Australia and the USA, comprising individuals of all ages and from different ethnic groups. The restriction of this review to studies in these countries means that the findings may not be applicable to the experiences of detainees in the rest of Europe.

All studies found high levels of emotional distress among individuals who were in detention or who had been previously detained. Among children, mental health difficulties in combination with developmental and behavioural problems were observed.\textsuperscript{17,28} Although in its infancy, research into the effects of detention has used increasingly sophisticated methods in order to attempt to identify and isolate the independent effects of numerous adverse circumstances on the mental health of these individuals. This has produced evidence that the findings relate in part to pre-detention trauma experiences, in addition to detention itself having an independent adverse effect on mental health.

The combination of quantitative and qualitative findings has enabled investigation of both the extent and severity of mental health problems among detainees as well as allowing meaningful contextualised interpretations of how detention affects individuals. Anxiety, depression and PTSD in particular have been observed in all of the studies, although lower prevalence rates of mental health problems such as psychosis have also been reported.\textsuperscript{17,25,28} Self-harm and suicidal ideation were also widely reported.\textsuperscript{15,18,28} Qualitative studies have suggested that psychological factors influencing the mental health of detainees include feelings of hopelessness and a sense of injustice.\textsuperscript{7} This suggests that both the psychological impact of detention as well as factors relating to the detention environment may adversely affect mental health.

Sampling methods targeting individuals who had experienced detention but had been released at the time of the study, as well as the inclusion of follow-up data, have allowed investigation of the longer-term impact of detention. Longer periods of detention are associated with worse outcomes.\textsuperscript{16,17,23} Symptoms were found to be linked to specific experiences in detention.\textsuperscript{25} Although improvement in symptoms subsequent to release has been reported,\textsuperscript{19} Steel et al found that longer periods of detention were still associated with poorer mental health outcomes 3 years following release.\textsuperscript{23} Although few studies have investigated this issue, these preliminary findings suggest that the harmful effects of detention remain, despite initial improvement following release. Further research is required to address the longitudinal impact of detention on mental health, as well as subsequent social acculturation processes. This issue is further complicated by the
The highly contentious nature of these issues results from the numerous conflicts of interest between governmental, scientific and clinical bodies. This has escalated as evidence attesting to the harmful effects of detention on mental health has accumulated, to the extent that researchers have been accused of furthering political agendas through research. There is a real danger that research access to people in asylum detention may be limited by concerns over the political implications of the research findings. Given the severity of mental health implications for those held in detention suggested by the studies reviewed here, it is imperative that access is granted to allow scientific research in this area to continue.

References

Psychiatrists in 19th-century fiction

The Rose and the Key (1871), J. Sheridan LeFanu

Fiona Subotsky

The Rose and the Key is one of Sheridan Le Fanu’s sensation novels, without any supernatural elements. It is set in England rather than Ireland, for better sales.

The heroine, Maud, is deceived into entering a lunatic asylum on the pretext that she is visiting the great house of Lady Mardykes. Evidence as to Maud’s insanity has been gained by a strange evangelical called Elihu Lizard, who notes her playful claims of another identity and puts this down to delusion. Her mother, Lady Vernon, testifies to a suicide threat. Two sinister doctors, Dr Malkin the local practitioner and Dr Antomarchi an asylum administrator, collude with Lady Vernon, all hoping to gain by the prevention of Maud’s marriage. Dr Damian, the local magistrate, also eager to keep the approval of Lady Vernon, acts to endorse the arrangement legally.

Antomarchi an asylum administrator, collude with Lady Vernon, all hoping to gain by the prevention of Maud’s marriage. Dr Damian, the local magistrate, also eager to keep the approval of Lady Vernon, acts to endorse the arrangement legally.

Dr Michael Antomarchi has the key medical role. Obviously, he is ‘foreign’ and has a striking appearance – with ‘marble feature, strange eyes, and coal-black square beard.’ He is an expert in mesmerism, and controls the asylum (appropriately named ‘Gareswood’) with his fierce gaze and stern authority. He cows Maud into compliance by making her witness a forcible shower-bath followed by an emetic, which leaves the patient nearly dead. Le Fanu steps back from the narrative here, to point out that such a case was indeed investigated by the Lunacy and stern authority. He cows Maud into compliance by making her witness a forcible shower-bath followed by an emetic, which leaves the patient nearly dead. Le Fanu steps back from the narrative here, to point out that such a case was indeed investigated by the Lunacy Commission, but that now such a practice ‘is no longer countenanced by the faculty.’

Antomarchi is ambitious: he hopes to take over the asylum soon, and meanwhile is prepared to take money in excess from Lady Vernon. He wants to be ‘monarch of all I survey’. The same expression was later used by Henry Maudsley in his autobiographical recollection of his time as medical superintendent at Cheadle, adapting a verse by William Cowper:

‘I am monarch of all I survey,
I am lord of the fool and the brute,
From the centre all round to the sphere,
My rite there is none to dispute.’

Although Maudsley achieved this, as is the nature in romances the ‘brilliant rogue’ Antomarchi has his evil plans foiled, and is compelled to leave the country, ending in ‘sore straits’.


312
<table>
<thead>
<tr>
<th>Study</th>
<th>Place of study</th>
<th>Sample size</th>
<th>Sampling technique</th>
<th>Geographical/ethnic origin of sample</th>
<th>Retrospective/ current detention</th>
<th>Legal status</th>
<th>Design</th>
<th>Comparison group</th>
<th>Measures</th>
<th>Results and main findings</th>
</tr>
</thead>
</table>
| Bracken & Gorst-Unsworth (1991)   | UK             | n=10 detainees | Opportunity sampling | Not reported                        | Current                        | Asylum seekers | Case series | No              | Clinical interview no measures reported                                                  | 100% high-level psychological disturbance  
100% depressed  
40% suicide ideation  
20% suicide attempts                                                   |
| Pourgourides et al (1996)         | UK             | n=15 detainees, n=45 focus group participants | Opportunity sampling | Nigeria, Algeria, Angola, China, Libya, Uganda, Zaire, Pakistan, Iran | Current | Asylum seekers and failed asylum seekers | Individual semi-structured interviews and focus groups | Psychiatric diagnostic interviews (DSM-IV) | 27% PTSD  
60% depression  
7% panic disorder  
7% psychosis                                                      |
| Thompson et al (1998)             | Australia      | n=221 detainees (23 detained asylum seekers; 62 non-detained asylum seekers; 30 refugees; 104 immigrants) | Opportunity sampling | Sri Lankan Tamils | Mixed | Mixed | Between groups, questionnaire | Three comparison groups (non-detained asylum seekers, refugees and immigrants) | HTQ; Depression, Anxiety and Somatisation Scale of HSC–25; Four Measures of Mental Health, Panic Scale; self-report of exposure to post-migration stressors | Higher levels of traumatic experiences, as well as higher rates of depression and suicidal ideation, anxiety, panic and post-traumatic stress among detainees |
| Sultan & O’Sullivan (2001)        | Australia      | n=33 detainees | All detainees meeting inclusion criteria invited to participate | Ten countries | Current | Asylum seekers and failed asylum seekers | Semi-structured interviews | No | Clinical interview; no measures reported | 85% chronic depressive symptoms  
65% suicidal ideation  
21% psychotic features                                                   |
| Keller et al (2003)               | USA            | n=70         | Opportunity sampling | Africa (77%); eastern Europe, Asia, Middle East, South America | Mixed | Asylum seekers | Repeated-measures questionnaire | No | PTSD sub-scale of HTQ, HSC–25 | Clinically significant levels of anxiety (77%), depression (86%) or PTSD (50%) at baseline  
Symptom severity associated with length in detention, and improved after release  
Individuals still detained had increased symptom scores |
All children had at least one parent with mental health problems |
| Steel et al (2004)                | Australia      | n=34 (14 adults, 20 children) | Targeted sampling | Not reported, all from same ethnic background | Current | Failed asylum seekers | Clinical assessment | No | Clinical diagnostic interview (SCID–IV or K–SADS–PL) and self-report questionnaires:  
parenting questionnaire, Detention Symptom Checklist, Detention Experiences Checklist | All met diagnostic criteria for at least one psychiatric disorder  
Exposure to trauma in detention was common  
Parents reported feeling unable to care for children |

(continued)
<table>
<thead>
<tr>
<th>Study</th>
<th>Place of study</th>
<th>Sample size</th>
<th>Sampling technique</th>
<th>Geographical/ethnic origin of sample</th>
<th>Retrospective/current detention</th>
<th>Legal status</th>
<th>Design</th>
<th>Comparison group</th>
<th>Measures</th>
<th>Results and main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Momartin et al (2006)</td>
<td>Australia</td>
<td>n=116</td>
<td>Consecutive case referrals</td>
<td>Iran and Afghanistan</td>
<td>Retrospective</td>
<td>Refugees</td>
<td>Between-group comparison</td>
<td>Yes (67 permanent protection visa holders who had not been detained)</td>
<td>HTQ, HSC–25, GHQ–30, mental and physical component summaries of the SF–12, post-migration living difficulties checklist, Detention Experiences Checklist</td>
<td>Higher levels of anxiety, depression and PTSD in temporary visa protection holders v. those with permanent protection</td>
</tr>
<tr>
<td>Steel et al (2006)</td>
<td>Australia</td>
<td>n=241</td>
<td>Snowball</td>
<td>Sabian Mandaeans (Iran and Iraq)</td>
<td>Retrospective</td>
<td>Refugees</td>
<td>Questionnaire Within- and between-group comparisons</td>
<td>No</td>
<td>HTQ, HSC–25, mental and physical component summaries of the SF–12, post-migration living difficulties checklist, Detention Experiences Checklist, Detention Symptom Checklist</td>
<td>Detention and temporary protection each contribute independently to risk of depression and PTSD. Longer periods of detention are associated with more severe disturbance</td>
</tr>
<tr>
<td>Arnold et al (2006)</td>
<td>UK</td>
<td>n=56 detainees</td>
<td>Consecutive case referrals</td>
<td>Not reported</td>
<td>Mixed</td>
<td>Failed asylum seekers</td>
<td>Consecutive case series</td>
<td>No</td>
<td>Psychiatric diagnostic interviews (ICD–10)</td>
<td>59% PTSD or depression</td>
</tr>
</tbody>
</table>

Mental health implications of detaining asylum seekers: systematic review
Katy Robjant, Rita Hassan and Cornelius Katona
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Supplementary Material
Supplementary material can be found at:
http://bjp.rcpsych.org/content/suppl/2009/04/01/194.4.306.DC1

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