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Van Hout, MC, Lungu-Byrne, C and Germain, J

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Abstract

Purpose

Many migrants are detained in Europe not because they have committed a crime but because of lack of certainty over their immigration status. Whilst generally in good physical health on entry to Europe, migrant detainees have complex health needs, often related to mental health. Very little is known about the current health situation and health care needs of migrants when detained in European immigration detention settings.

Design/methodology/approach

We undertook a synthesis of extant qualitative literature on migrant health experience and health situation when detained in European immigration detention settings; retrieved as part of a large scale scoping review. Included records (n=4) from Sweden and the United Kingdom representing both detainee and staff experiences were charted, synthesised and thematically analysed.

Findings

Three themes emerged from the analysis: ‘*Conditions in immigration detention settings*’; ‘*Uncertainties and communication barriers*’ and ‘*Considerations of migrant detainee health*’. Conditions were described as inhumane, resembling prison, and underpinned by communication difficulties, lack of adequate nutrition and responsive health care.

Practical implications.

It is crucial that the experiences underpinning migration are understood in order to respond to the health needs of migrants, uphold their health rights and to ensure equitable access to healthcare in immigration detention settings.

Originality/value

There is a dearth of qualitative research in this area due to the difficulty of access to immigration detention settings for migrants. We highlight the critical need for further investigation of migrant health needs, so as to inform appropriate staff support and health service responses.

Keywords: Migrant; Immigration Detention, Refugee, Health Rights

Background

Globally, migrants account for upwards of 258 million people – a twofold increase since 2000 and threefold since the 1970s (Douglas *et al.*, 2019). The International Organization for Migration (IOM) (2019:130), defines a migrant as “*any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person’s legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is*”. In 2015, approximately 3.5% of the global population were defined as ‘*international migrants*’, of which 10% had moved to Europe (Geddes and Scholten, 2016). In that year, the European Border Agency Frontex estimated that over 1.83 million people entered the European Union (EU). Since then, Europe has been challenged by the so-called “*refugee and migrant crisis*”, (Horyniak *et al.*, 2016) and has had to deal with an influx of increasing numbers of ‘*forced migrants*’ fleeing from conflict, political tensions or terrorism, and asylum seekers (Van Hout *et al.*, 2016). Source countries are from the Middle East (Syria, Iraq, Afghanistan) and other countries such as Pakistan, Eritrea, Somalia, Nigeria and Sudan. EU Initiatives such as the EU Turkey deal and EU Measures to curb migration from Libya have led to some reduction in irregular migration. Despite these initiatives, human smuggling has emerged as one of the most profitable and widespread criminal activities for organised crime ‘*criss-crossing*’ the Middle East and North Africa to connect with southern and eastern EU member states, and is strongly inter-linked with drugs and weapons trade (Van Hout *et al.*, 2016). North African, Syrian and western European crime syndicates are strongly implicated in facilitating migrant escape from conflict zones and migrant camps from the Middle East to Europe, and also in the exploitation of migrants to commit crime on entry into Europe.

This has led to a recognised ‘*superdiversity*’ in Europe which poses significant difficulties to security, border control and detention or prison operations (Gallez, 2018), and concurrent increased diversity of origin and profile of populations detained or incarcerated in Europe (Ugelvik, 2017; Banks, 2018; Rope and Sheahan, 2018; Walmsley, 2018). Individuals of “*national, ethnic, religious or linguistic minority groups*” experience persistent discrimination in EU criminal justice systems, and are generally detained, charged and incarcerated for longer periods than the rest of the population (Rope and Sheahan, 2018). Many are detained in Europe, not because they have committed a crime but because of lack of certainty over their immigration status. Specific monitors are recommended to clearly distinguish between those detained on the basis of their immigration status (immigration detention) and those who have committed a crime (foreign national prisoners) (Penal Reform International, 2016). Detention is defined as restriction on freedom of movement through confinement ordered by an administrative or judicial authority (IOM, 2011). It is an administrative step taken to enforce a deportation order, verify identity documents or a claim for asylum, and for national security to enforce public health measures (Silove *et al.*, 2007; Mendonça, 2010; IOM, 2011; Steel *et al.*,

2011; UNHCR, 2012). Both national and international guidelines advocate that immigration detention should only be used as a last resort.

There is a growing critical need for countries and international communities to “*devote greater attention and commitment to upholding the human rights of migrants*” in immigration detention (Acer and Goodman, 2010). Despite the recognition of health and social vulnerabilities of migrant populations in Europe, EU wide specific health monitoring and sensitive health care approaches vary in terms of coverage, access, uptake and retention of care of migrants (Rechel *et al.*, 2011; Mladovsky *et al.*, 2012). Health needs of migrants have not been consistently addressed and they often lack equitable access to adequate health services (IOM, 2017). This compounds migrant health vulnerabilities and health disparity (Spiegel and Golub, 2014; Frontex, 2015). Data for health profiles of migrants in Europe remains patchy making it difficult to monitor and improve (Rechel *et al.*, 2013). Frequently, anti-immigration governmental groups politicise the health risks that newly-arrived migrants pose on host countries with an aim to fabricate a ‘*climate of fear*’ encompassing migration, despite evidence contrary to this, whereby upon arrival into host countries, migrants generally have good health (the ‘*healthy migrant effect*’; Rousseau and Frounfelker, 2019). However, this effect is observed in epidemiological studies based on economic migrants, often young men in good health. In contrast, ‘*forced migration*’ causes significant negative mental and physical consequences compounded by adverse socioeconomic conditions and very stressful living situations in the country of origin, particularly for those fleeing persecution or war. Vulnerability to poor health generally develops in transition or in the host country as a result of poverty, poor living conditions, lifestyle changes, fears around personal security, conflict related trauma, lack of access to healthcare and interrupted care during displacement (Derose *et al.*, 2007; Van Hout *et al.*, 2016; Arie, 2019; WHO, 2019; WHO European Health Policy Framework-Health, 2020). Their social and health related vulnerabilities are further compounded if they transit through refugee camps where some have been found to be ‘*dangerous melting pots*’ of inter-ethnic conflict, sexual assault, violence and crime (Van Hout *et al.*, 2016). Migrants’ vulnerabilities are often exploited in criminal networks, therefore exposing them to increased risk and harm, for example regarding virus acquisition, labour bond, and death. A significant proportion of migrants and refugees living with HIV in Europe acquired the infection after arriving in the host country (WHO, 2018), likely a result of their vulnerability to risk (ECDC, 2018; Arie, 2019; WHO, 2019).

It is therefore crucial that the experiences underpinning migration are understood in order to respond to the health needs of migrants, asylum seekers and refugees, uphold health rights and to ensure equitable access to healthcare (Grove and Zwi, 2006; Abbas *et al.*, 2018). This is also particularly important in immigration detention settings. There is limited research on how people adapt to the detention environment, or how to ensure sufficient measures for their health and wellbeing (Venters *et al.*, 2009; Coffey *et al.*, 2010; Hollings *et al.*, 2012). Whilst we recognise that in many European countries, migrants are systematically detained in prisons, temporarily constructed

camps, airports and specialised detention centres (Venters *et al.*, 2009, Mendonça, 2010; Steel *et al.*, 2011), we undertook a synthesis of extant qualitative studies on migrant health experience and health situation when detained in European immigration detention settings. Studies were retrieved as part of a large scale scoping review on migrant health experience and health situation when detained and incarcerated in Europe. We report here on the distinct qualitative material available from immigration detention settings, as opposed to prisons where healthcare tends to be better, more accessible and in line with the United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), the Basic Principles for the Treatment of Prisoners, and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.

Methods

Scoping review methodologies have become a progressively favoured approach for synthesising research evidence, particularly when inspecting emerging evidence or under researched topics (Pham *et al.*, 2014; Munn *et al.*, 2018). Such reviews are defined as a type of research synthesis that aims to ‘map the literature on a particular topic or research area and provide an opportunity to identify key concepts; gaps in the research; and types and sources of evidence to inform practice, policymaking, and research’ (Daudt *et al.*, 2013). A number of reviews have utilised this method when investigating closed setting health standards and the health situation of key prisoner populations (Van Hout and Mhlanga-Gunda, 2018; Van Hout and Mhlanga-Gunda, 2019a:b). We adhered to Arksey and O’Malley’s (2005) iterative scoping review framework consisting of the following key stages: (1) identifying the research question; (2) identifying relevant studies; (3) study selection; (4) charting the data; (5) collating, summarising and reporting the results. The underpinning research question was; ‘What is known in the qualitative literature about migrant detainees’ health experience and unique health care needs when detained in European immigration detention settings?’. We adopted the IOM (2019) definition of migrant. Extensive searches were conducted in the following databases: Web of Science, MEDLINE, PsycINFO, CINAHL, and Scopus. Searches were restricted to the publication timeframe 2014-2019 (the timeframe of the European migrant influx), and limited to empirical records representing qualitative studies from EU member states and in the English language. Studies describing the views and experiences of those detained as well as immigration detention centre staff were included. See **Table One**.

Insert **Table One – Search Terms** about here

Citations from database searches were imported and managed using reference software EndNote. References were scanned and duplicates were removed. We adopted a two-stage screening process consisting of (1) preliminary title and abstract screening and (2) full text screening. Once all duplicates (n=123) were removed, the title and abstracts of the remaining records (n=580) were

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screened. Empirical records considered not relevant were excluded at this stage (n=525). Of the remaining total (n=55), two articles were not in English and full text versions of six articles could not be retrieved, so these were excluded. A full text screening of the remaining empirical records (n=47) was conducted by the team with 34 articles excluded which did not employ qualitative methods. Detailed inclusion and exclusion criteria are presented in **Table Two**. See **Figure One**.

Insert **Table Two- Inclusion and exclusion criteria using PICO framework** about here

See **Figure One**.

Insert **Figure One ‘Flowchart’** about here

Following the application of the two-stage screening process, four full text qualitative papers were charted, and summarised. A data extraction form was developed which included data on: year of publication, author, location, study aims, methodological design, sample characteristics, type of qualitative data collection and analysis approaches and key findings. The scoping review process of data extraction was guided by the eligibility criteria in order to establish validity and maintain focus on the research question. We subsequently conducted a qualitative synthesis, defined as the “*process of pooling qualitative and mixed-method research data, and then drawing conclusions regarding the collective meaning of the research*” (Bearman and Dawson, 2013). This interpretative synthesis of the four studies took the form of several steps: 1) line-by-line coding of primary data supported by NVivo version 12; 2) organization of codes into corresponding groups using an iterative process in developing themes and sub themes; 3) refining and reviewing of themes by the team as a collective in terms of internal homogeneity and external heterogeneity, examination of coherence of patterns across themes and development of a thematic map, and 4) final clear definition and naming of themes, with data extracts representing and articulating the essence of the theme, and overall analysis.

Results

The scoping review revealed a very limited evidence base pertaining to empirical research using qualitative methods on migrant health situation when detained in European immigration detention centres. We speculate that this may be due to difficulties in gaining access to this unique population and closed setting. Across the four studies which originated in two EU member states (United Kingdom, Arshad *et al.*, 2018; Hollis, 2019 and Sweden; Puthoopparambil *et al.*, 2015a: b), 37 detainees (of which six were pregnant detainees), and 15 staff were interviewed. See **Table Three**.

Insert **Table Three – ‘Charted Records’** about here

Three themes emerged from the qualitative synthesis: ‘*Conditions in immigration detention settings*’; ‘*Uncertainties and communication barriers*’ and ‘*Considerations of migrant detainee health*’. Where possible we include illustrative quotes from the perspectives of migrants, and/or staff working in the immigration detention setting.

Conditions of immigration detention

Living conditions in the immigration detention settings were described as detrimental to health across all studies. Hollis (2019) illustrated a detainee’s description of how he felt after being sent to an immigration removal centre: “*For want of a better word, gutted. I mean shock, disbelief, helplessness and, and do you know, your whole life is just changed now. You think, oh my god, I’m in this position now, and it brings on hopelessness*”. Migrant detainees, in disbelief and shame, often concealed their detention from family. Those entering detention in good health appeared to be losing their identities and searching desperately for ways to cope. Hollis (2019) described the psychological impacts of this environment on detainees, where a detainee described their feelings of depression, anxiety and hopelessness: “*It’s the surroundings. It’s what you’re in. You are in a place with 250 other people – and of the 250, there’s 10 happy ones. And the rest are just really at various stages. From really desperate, to suicidal, to depressed. It’s not a place to be for any length of time*”. A Kurdish detainee described their first night in detention as: “*The first night in detention I can never forget. When I was put in a single cell with no food. And I was hungry and lonely. Because this happened in a country where there should be human rights and respect for human rights. I can never forget that*” (Hollis, 2019).

Insufficient and poor quality of food was reported, and impacted particularly severely on pregnant and breastfeeding migrant women. Arshad *et al.* (2018) in their study on UK detention centres, described the food as poor quality, unpalatable, inadequate, as well as stating that timing of meals was inflexible, and there was not a balanced diet. Pregnant detainees in this study reported that “*The food was appalling, like, it was basically just chips. They were supposed to provide a balanced diet but they didn’t*” and “*The food was too spicy...I didn’t like the food. I was vomiting all the time and just eating to keep surviving for my baby*”. Similar was illustrated by Hollis (2019) whereby a pregnant Pakistani woman described how she was unable to eat the food provided and begged for an alternative: “*I had very severe morning sickness. Very severe, you can’t imagine. I couldn’t go for six months in dining room. I never eat food, for six months of pregnancy. It was, just, orange in a whole day, one orange. Sometimes nothing. I cried for plain rice. Can I eat? But, I couldn’t, I couldn’t*”. In Sweden, detainees described the conditions of the immigration detention setting as disgusting, with poor hygiene in toilets and bathrooms and a lack of sanitation (toilet paper, soap) (Puthooppambil *et al.*, 2015b). They reported concern for infection with disease: “*This is not real life, if you want to know how one is living, come here and live here for two nights [...] You [...] go to the toilet and really see the disgusting part of life and when you go to the room [...] one is snoring and another one*

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smells bad. When you put your head on the pillow and want to sleep, it smells disgusting and then you will find out what kind of place this is.” (Puthoopparambil *et al.*, 2015b).

The environment of the immigration detention setting was described in all studies as tense, with a lack of privacy and feelings of safety, and with abusive and controlling staff behaviour. This was especially the case in the UK, where detention officers would enter female detainees rooms to perform random checks without any warning, including when they were having a shower or visiting the toilet. A pregnant detainee stated: *“When I go to the toilet I feel scared there because the guards they can just come in at any time...I feel they can come in when I am changing...so I write a note and put it on the door and the male officer took and said I can’t put anything like that”* (Arshad *et al.*, 2018). In Sweden, detainees reported feeling threatened by the authorities and described a lack of personal safety and being under constant staff surveillance. They were threatened by staff to cooperate with the deportation process or they would face long-term detention or transfer to the police in their home countries: *“Last time I got a visit from the [police] inspector, she was telling me “If you don’t give us your document you will stay here forever [...] or we will hand you over to the authorities in your home country” and the whole conversation was carried out in a very stressful way with shouting”* (Puthoopparambil *et al.*, 2015b). Puthoopparambil *et al.*, (2015a) in their study on staff perspectives reported that the main challenge for staff in Swedish immigration detention settings was to manage the emotional dilemmas as immigration officers whose task was to implement deportation decisions while also being expected to provide humane service to detainees: *“You have to be a human . . . So you are just to set a line between your professional and your social emotions. It is sometimes very complicated and difficult. But we try to . . . balance so we don’t fall into emotional things.”* (Puthoopparambil *et al.*, 2015a). This study also underscored the tense working environment for staff in terms of potential for physical threat from detainees, high reliance on their colleagues for personal safety and the importance of awareness of dynamic security. This was viewed by staff as contributing to limited contact between staff and those detained: *“I think that the most important thing for me is dynamic security. I must have a relationship [connection] with all the detainees. It doesn’t help that much with the [physical] security and routines. It is important, but there are 25 of them and four of us, if they do something we don’t have a chance. That’s why it is important to have a good relationship with everyone.”* (Puthoopparambil *et al.*, 2015a).

Uncertainties and communication barriers

The continuous uncertainty faced by those detained appeared to be highly distressing across all studies. Uncertainties were mostly related to the slow and constant changes in asylum procedures as well as a lack of information. Puthoopparambil *et al.*, (2015b), in their Swedish study, illustrated how detainees described stressors in detention, controlled by the system and forced into passivity, and who likened detention to prison. This was also observed by staff in a Swedish immigration detention centre

who said: *"I don't really like it because I think it shouldn't be necessary to have places like this. But the system is like this and there are so many people who are not following the decisions. We need to keep them somewhere until they can go home"* (Puthoopparambil *et al.*, 2015a). Puthoopparambil *et al.*, (2015b) reported on detainee experiences where those who had been detained in more than one centre, described differences in staff behaviour towards them: *"There [detention unit X] they are friendly [...] They greet you and say 'Hello, I am [name], where do you come from, what problems do you have?' [...] They show they care and they talk in a way so you become calm"*.

Language and communication were identified as major challenges for foreign detainees. It appeared that those detained who did not understand host country's national language were more disadvantaged than those that did, which as a result negatively impacted the detention process. According to Hollis in 2019; six of the seven asylum seekers interviewed, arrived in detention with limited English language proficiency, and, as a result, were unable to understand basic information about where they were and why: *"When I received a letter, I couldn't understand it. Just give the letter to someone else. And then they can only tell me if the letter was bad or good, and nothing else"* (Hollis, 2019). A Pakistani woman described being questioned by an emotionless Home Office caseworker as *"But you know the man, it was not a man...It seems that he is a machine, he's a computer, just typing, just asking questions. I was crying...and I was thinking, he will never understand what I am saying. You know it made me, like, very low after the interview"* (Hollis, 2019). The inadequacy and inconsistency of communications was frequently documented by migrant detainees as a large stress factor that was found to exacerbate their mental health. A detainee in the UK described how he became disempowered by the system due to communications mostly consisting of complicated letters which he was unable to understand: *"It was so, so horrible. When I received a letter, I couldn't understand it. Just give the letter to someone else. And then they can only tell me if the letter was bad or good, and nothing else"* (Hollis, 2019). Similar was reported in Sweden where a detainee described the absence of proper support mechanisms and how incomplete translations provided by staff compounded their lack of trust: *"They will just give you papers [to] sign and they read the paper to you. But, what they are reading to you, is it correct? You don't know [...] they ask me to sign [...] I sign [...] sometimes you sign for something you don't know and it is crazy. How can you sign for something that you don't understand?"* (Puthoopparambil *et al.*, 2015b). This lack of common language with fellow detainees/staff was also reported to increase stress levels of detainees in Sweden (Puthoopparambil *et al.*, 2015b).

Considerations of migrant detainee health

Migrant health experience, consideration of their health and wellbeing, and the provision of appropriate, responsive healthcare in immigration detention settings in all four studies appeared sub-standard. Restricted basic human interaction and distance from their friends and families was reported

to increase stress levels of detainees in Sweden (Puthoopparambil *et al.*, 2015b). The lack of adequate healthcare for those detained, failure to identify those with complex health needs, and provision of sufficiently trained staff in the immigration detention centres was a salient issue, reported by both staff and those detained (Puthoopparambil *et al.*, 2015a,b). This is of concern considering the confined living space, stressful situation and frequent denial of requests for hospital appointments by the detainees (Puthoopparambil *et al.*, 2015b). Many staff also described not having enough time to spend with detainees, and the lack of suitable social and educational activities for free time (gym, TV, computers) (Puthoopparambil *et al.*, 2015a). Coping mechanisms of those detained included sleeping, isolation, taking sedative medication and hitting the walls.

The detention environment was found to impact mental health to such an extent that participants felt suicidal, self-harmed or attempted suicide (Arshad *et al.*, 2018; Hollis, 2019). Immigration detention staff in the UK appeared unaware of the effects of detention, as well as pregnancy, on prisoners' mental health (Arshad *et al.*, 2018). Arshad *et al.* (2018) described a sense of powerlessness over one's health; *"I was depressed, I was stressed...just being isolated, no privacy, men walking in...feeling powerless"*. All of the pregnant women interviewed in this study had a previously diagnosed mental health condition which they felt was exacerbated due to their circumstances: *"When it came to mental health, it's only about what someone says; there's little physical to see, so the women were always completely dismissed"* (Arshad *et al.*, 2018). Detainees in the UK study by Hollis (2019) also described feelings of depression, anxiety and hopelessness; *"the very fabric of detention – 'what you're in' – renders a state of depression all but inevitable. All but a very small minority of people in detention appeared to him susceptible to some emotional torment"*. Detainees in the UK described awareness of peer suicide attempts whilst in detention: *"Because the situation was so, so hard, that the Iranian boy – he hanged himself by rope. To kill himself. But he wasn't successful. The situation then was so, so horrible"* (Hollis, 2019).

The organisation of medical assistance was noticeably criticised by many detainees. In Sweden, detainees reported inadequate responses from nurses, and the inability to consult a doctor outside of the centre (Puthoopparambil *et al.*, 2015b). Language issues were recognised as a core challenge in accessing suitable healthcare (Puthoopparambil *et al.*, 2015b). Difficulties in accessing medical care was described in the UK: *"Most of the time, I just took the tablets, and I was unconscious on my bed, sleeping. I rarely ate lunch...When I saw myself in the mirror, it gave me a very bad feeling about myself – about my health, my back. And no one helped. I was so sad because of this"* (Hollis, 2019). Detention staff appeared not to recognise that mental health could deteriorate in detention and in pregnancy, and women were not listened to when they expressed concerns about their deteriorating health: *"I had bad experience with urinary tract infections...I used to be trafficked woman...I told officer 'please can I see doctor?' he told me 'doctor will come later'...I feel like I'm dying, I couldn't walk...I feel like they didn't care for me...I feel like they treated me like dog"* (Arshad *et al.*, 2018). Regarding maternity care, Arshad *et al.* (2018) identified a lack of continuity of

care with disrupted antenatal care due to a lack of available midwives in the immigration detention setting. A detainee said: *"I would like to see the midwife because I would like to know what's happening...I just want to hear my baby heart beat...so I would wait all day but the midwife never come back to see me"* (Arshad *et al.*, 2018). There were frequent cancellations of external consultations due to a shortage of security staff: *"I remember very well I had to for a scan...and they said, "no we don't have the security, we don't have so many people that can go with you"* (Arshad *et al.*, 2018). This study also reported concern about a lack of privacy when receiving care from health professionals in the immigration detention centre, and disrupted provision of prescribed medication. One woman described her thoughts after not receiving her medication: *"I feel suicidal...I was scared for my baby...what's going to happen next"*, illustrating uncertainty and fear of the future" (Arshad *et al.*, 2018).

Discussion

We have presented a scoping review with synthesis of extant qualitative literature on migrant health experience and health situation when detained in European immigration detention settings. Our review highlights the dearth of qualitative research in this field, and illustrates the complexities of the detention environment and vulnerability of migrant health when detained in Europe. We highlight that immigration detention settings may not be responding adequately or in a culturally sensitive manner to the particular needs of migrants. There is a critical need for EU countries to give greater attention and commit to protecting migrants' human rights including their health rights when detained (Acer and Goodman, 2010). It further highlights the need to train and better support immigration detention staff who are an integral part of the immigration detention environment, and who affect and are affected by detainees' health and wellbeing (Puthoopparambil, *et al.*, (2015a). Staff and detainee interaction is a major factor influencing the detention environment, and detainees experience it as imprisonment (Robjant *et al.*, 2009; Hall, 2010; Klein and Williams, 2012).

Migrants, having witnessed violence, lost family members, or been victims of rape, torture, trafficking, forced marriage and sex working, are an extremely vulnerable group with complex mental health needs. Migrants who are detained experience unique health challenges relating to post traumatic stress disorder, depression, anxiety and other mental health problems resulting from past experiences (Lindert *et al.*, 2008; Close *et al.*, 2016; WHO, 2018). They already experience a host of social and health related vulnerabilities, with heightened risk for substance use disorders due to lived trauma, co-morbid mental health disorders, acculturation challenges and poverty (Van Hout *et al.*, 2016). In addition to the restriction on liberty, the immigration detention environment plays a further major role in aggravating health and wellbeing of detainees (Silove *et al.*, 2007; Robjant, *et al.*, 2009; Venters *et al.*, 2009; Steel *et al.*, 2011; Silverman and Massa, 2012), with detention conditions shown

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to exacerbate pre-existing mental health conditions (Sen *et al.*, 2014; Arshad *et al.*, 2018; Sen *et al.*, 2018; von Werthern *et al.*, 2018; Hollis, 2019; Till *et al.*, 2019).

Our synthesis spans the unique detention environment, the uncertainties of the immigration detention process, and the inabilities to access supportive medical and health care. It highlights the need for greater focus on ensuring the health and wellbeing of detainees through the environment of the setting itself, addressing the inherent difficulties in communication, ethnic variation and differing degrees of health literacy in migrant groups, and promoting supportive security and healthcare staff who operate these settings. A lack of sufficient healthcare, inadequate nutrition, deficient living conditions, an absence of translated information, lack of privacy and inadequate healthcare provision for migrants has been consistently reported elsewhere in studies set in Spanish prisons, Swedish and UK immigration detention centres and Greek refugee camps (Ruiz-Garcia and Castillo-Algarra, 2014; Kalengayi *et al.*, 2015; Puthoopparambil and Bjerneld, 2016; Arshad *et al.*, 2018; Eleftherakos *et al.*, 2018; Gallez, 2018; Hollis, 2019). Lack of culturally competent care, and language issues in particular are recognised as core challenges in providing care for those detained or incarcerated in the UK, Sweden and Benelux countries (Sen *et al.*, 2014; Puthoopparambil *et al.*, 2015a:b:c; Puthoopparambil and Bjerneld, 2016; Mulgrew, 2016; HRW, 2016; Smith, 2017; Dexter and Katona, 2018; Prais and Sheahan, 2019). European countries are urged to strengthen the provision of culturally sensitive health services and competent health workers, specialised in migrant health, within immigration detention settings. Given that health in detention settings and public health are connected (Smith, 2018), it is imperative that immigration detention settings in all European countries equip themselves to provide continuous and appropriate healthcare to all migrants, and upscale their mental health responses given the traumas of displacement, conflict and detention experienced by those detained in a foreign country.

Conclusion

There is a dearth of qualitative research in this area due to the difficulty of access to immigration detention settings for migrants. We highlight the critical need for further investigation of the complexity of migrant prisoners needs relating to language, cultural sensitivity, mental health and detention processes when detained, so as to inform appropriate holistic responses within a continuum of care.

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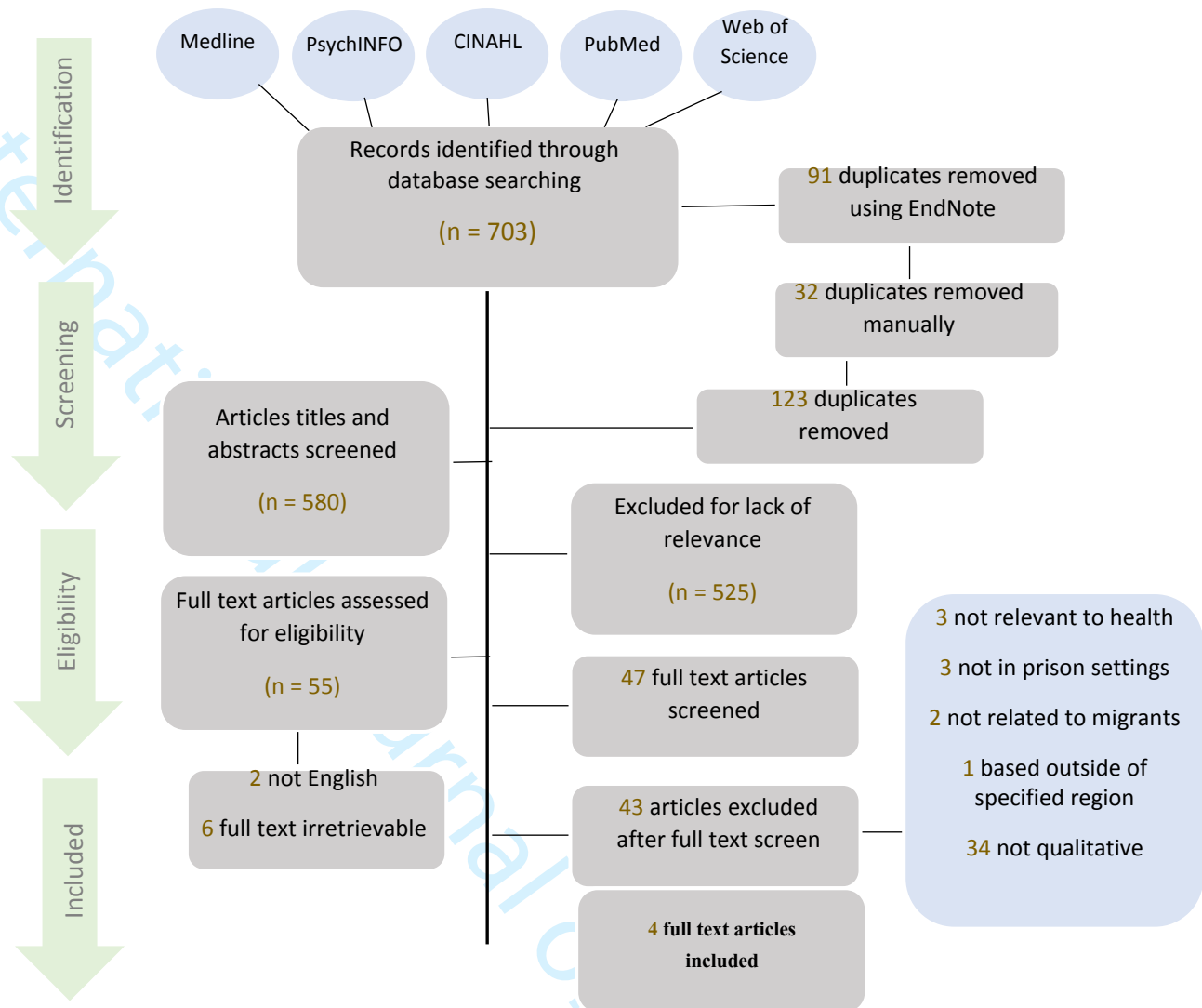


Table One – ‘Search Terms’

PICo concepts	#	Searches
Population	1	migrant* OR immigrant* OR "asylum seeker*" OR Refugee* OR Transient* OR Emigrant* OR "Displaced person*" OR "Displaced individual*" OR Foreigner* OR Expat* OR foreign* OR "foreign national*"
Phenomena of Interest	2	(health* AND policy OR policies OR guideline* OR scheme* OR law* OR legislation* OR document* OR program* OR service*) AND (Health* AND need* OR right* OR outcome* OR status*)
Context	3	(detention* OR "detained setting*" OR "place* of detention*") AND (Europe* OR EU OR Europe* countr* OR Europe* union* OR Europe* region* OR Austria* OR Belgium OR Belgian OR Bulgaria* OR Croatia* OR Cyprus OR Cypriot OR Czechia* OR Czech Republic OR Denmark OR Danish OR Estonia* OR Finland OR Finnish OR France OR French OR German* OR Greece OR Greek OR Hungary OR Hungarian OR Ireland OR Irish OR Italy OR Italian* OR Latvia* OR Lithuania* OR Luxembourg* OR Malta OR Maltese OR Netherland* OR Holland OR Dutch OR Poland OR Polish OR Portugal OR Portuguese OR Romania* OR Slovakia* OR Slovenia* OR Spain OR Spanish OR Sweden OR Swedish OR "United Kingdom" OR England OR English OR Scotland OR Scottish OR Wales OR Welsh OR "Northern Ireland" OR "Northern Irish")
Combining searches:	4	S1 AND S2 AND S3

Table Two- 'Inclusion and exclusion criteria using *PICo* framework'

PICo element	Include	Exclude
Population(s) Who is involved? What are the characteristics of the patient or population of interest?	<ul style="list-style-type: none"> Populations considered and identified as any of the following: migrants; asylum seekers; refugees; transients; immigrants; emigrants; displaced individuals; foreign nationals Of any age Of any gender 	<ul style="list-style-type: none"> Studies surrounding other population groups Studies focusing on individuals or staff working with group of interest, unless directly relevant
Phenomena of Interest Relates to a defined event, activity, experience or process (e.g. behaviours, experiences, or an intervention)	<ul style="list-style-type: none"> Views and experiences of health, health needs and rights, health outcomes and relevant health-related policies Studies surrounding general health, physical health, mental health, health needs, health rights, health outcomes Studies mentioning health-related policies Studies containing health-related content directly related to the population and context of interest 	<ul style="list-style-type: none"> Studies that do not report health experiences relating to the specified population
Context Where does the study take place? In what context? Any other distinct characteristics?	<ul style="list-style-type: none"> Immigration detention centres in any of the 28 EU member state countries 	<ul style="list-style-type: none"> Immigration detention centres outside of 28 EU member state countries
Research type	<ul style="list-style-type: none"> Qualitative English language Published between 2014-2019 	<ul style="list-style-type: none"> Quantitative Any type of review (i.e. systematic, literature) Languages other than English Published outside of specified timeframe

Table Three – ‘Charted Records’

AUTHORS	TITLE, JOURNAL/SOURCE, YEAR OF PUBLICATION	AIM	LOCATION	METHOD OF STUDY	RESULTS	CONCLUSIONS
Hollis, J	The psychosocial experience of UK immigration detention, <i>International Journal of Migration, Health and Social Care</i> , 2019	To explore and analyse the phenomenology of entering, living in and coping with life inside UK immigration removal centres (IRCs). Particular focus was placed on identifying psychosocial stressors in detention, the psychological impacts these stressors had on people who were detained, and the ways in which these individuals coped with their	Immigration Removal Centres in Scotland and England	9 in-depth interviews: with participants that were recruited through “Life After Detention” mutual-support group held weekly in Glasgow	Key themes include: Entering detention, life before detention, the shock of being detained, the powerlessness of detention, poverty of communication, negligence of healthcare, mental health impacts. resilience and coping in detention, coping styles, relationships in detention	Following the initial shock of detention, participants reported feeling powerless as a result of two main stressors. First, inconsistency and inadequacy of communications from immigration authorities was identified as a major stress factor experienced by detainees. Second participants found that their physical and mental health needs were neglected by custodial and medical staff on

		experiences and expressed resilience				site.’ -‘Six of the seven asylum seekers interviewed, arrived in IRCs with limited English language proficiency, and, as a result, were unable to understand basic information about where they were and why.’ - Neglect of basic healthcare was experienced Prioritise adherence to rules over basic human rights. Participants reported feelings of depression, anxiety and hopelessness All but a very small minority of people in detention appeared to him susceptible to some emotional torment.
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Arshad, F., Haith-Cooper, M. and Palloti, P.	The experiences of pregnant migrant women in detention: A qualitative study. <i>British Journal of Midwifery</i> , 2018	To explore pregnant migrant women’s experiences of living in detention, in order to understand maternity care provision and the effect of detention on women’s health	United Kingdom detention centres	6 in-depth interviews: undertaken with four migrant women and two volunteer health professionals	Key themes include: Challenges in accessing maternity care, exacerbation of mental health conditions, feeling hungry, lack of privacy	Antenatal care had been disrupted due to a lack of available midwives in the detention centre. Midwives provided appointments but there were not enough available for the demand. There was a lack of continuity of care. All the women had a previously diagnosed mental health condition which they felt was exacerbated due to their circumstances. Volunteers stressed that detention staff did not recognize that mental health could deteriorate in detention and in pregnancy and women were not listened to when they expressed
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						<p>concerns about their deteriorating mental health. Inappropriate medication. Food was poor quality, unpalatable and was not a balanced diet. Not enough food was provided and there was inflexibility in the timing of meals. Lack of privacy in detention centres.</p>
<p>Puthoopparambil, S., Ahlberg, B. and Bjerneld, M.</p>	<p>"It is a thin line to walk on": Challenges of staff working at Swedish immigration detention centres, <i>International Journal of Qualitative Studies on Health and Well-being</i>, 2015</p>	<p>To explore and describe experiences of detention staff in providing services for immigrant detainees. The study is part of a larger project aimed at identifying factors, which could mitigate the effects of detention on the health and well-being of</p>	<p>Three Immigration Detention Centres, Sweden</p>	<p>Fifteen semi-structured interviews were conducted with staff members (six females and nine males) including four supervisors, seven case officers, and four team leaders - in three Swedish</p>	<p>Results indicated that the main challenge for the staff was to manage the emotional dilemma entailed in working as migration officers and simultaneously fellow human beings whose task was to implement deportation decisions while being expected to provide humane service to detainees. They tried to manage their dilemma by balancing the two roles, but still found it challenging. Among the staff, there was a high perception of fear of physical threat from detainees that made detention a stressful environment. Limited interaction between the staff and detainees was a reason for this.</p>	<p>There is a need to support detention staff to improve their interaction with detainees in order to decrease their fear, manage their emotional dilemma, and provide better service to detainees. It is important to address staff challenges in order to ensure better health and well-being for both staff</p>

		detainees in Swedish immigration detention centres		detention centres. Interviews were analysed using thematic analysis.		and detainees.
Puthoopparambil, S., Ahlberg, B. and Bjerneld, M.	“A prison with extra flavours”: experiences of immigrants in Swedish immigration detention centres, <i>International Journal of Migration, Health and Social Care</i> , 2015	To explore and describe the perceptions and experiences of immigrant detainees in Swedish immigration detention centres. The study is part of a larger project aimed at identifying relevant factors that could mitigate the harmful effects of detention on the health and well-being of detainees.	Three detention centres in Sweden	Qualitative research design using semi-structured interviews (with 22 detainees)	The detainees likened immigration detention to imprisonment. They experienced lack of control over their life situation mainly through arbitrary restrictions and lack of proper response from authorities making it appear futile to seek help. This perceived lack of control forced them into passivity. Differences in amenities provided in the centres were observed and some of these were reported to assist in making detention more bearable. The county council in which the detention centre is located has the responsibility for providing health care services to the detainees. Health conditions which cannot be deferred (emergencies) should be attended to. All detention centres, except one, have a nurse visiting the centres once or twice a week. One detention centre has a nurse visiting five days a week. The three themes developed, stressors in detention, controlled by the system and forced into passivity, described the stressors experienced by the detainees	Alternatives to detention must always be pursued before resorting to immigration detention. However, if states deem detention to be necessary, it is important that the health and well-being of migrants in detention is not ignored. Immigrant detainees in Sweden experience detention as imprisonment and experience a lack of control over their life situation negatively affecting their health and well-

				<p>who likened detention to prison as it created a sense of lack of control, forcing them into passivity. Regarding absence of a proper support system and incomplete translation which was cited as a reason for them having a lack of trust in the staff: "They will just give you papers [to] sign and they read the paper to you. But, what they are reading to you, is it correct? You don't know [...] they ask me to sign [...] I sign [...] sometimes you sign for something you don't know and it is crazy. How can you sign for something that you don't understand?" As indicated earlier, detainees are known to have mental and physical illness. This indicates the need for increased availability and accessibility of health care services in detention centres. In Swedish detention centres, there is a lack of health care services, especially mental health care services. This is of concern considering the confined living space, stressful situation and denied requests for hospital appointments by the detainees. The examples indicate that even within the existing structural and legal framework, staff-detainee interaction could be improved, and arbitrary use of power could be avoided, giving greater control to detainees. This would increase their sense of control,</p>	<p>being. In order to mitigate the effects of detention on detainees' health and well-being, health care provision at the detention centres should be improved, arbitrary restrictions in detention should be avoided and staff-detainee interaction should be improved.</p>
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					reduce the feeling of imprisonment, and thus mitigating the effects of detention on the health and well-being of the detainees.	
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