Contemporary migrant health experience and unique health care needs in European prisons and immigration detention settings.

Abstract

Coinciding with mass population movement of migrants into Europe, populations of those incarcerated and detained in prisons and immigration detention settings have diversified significantly. A scoping review mapped and described extant literature on migrant health experience and unique support needs in these settings. Fifteen records fulfilled inclusion criteria and indicated that migrants are generally in good health on intake/committal, but have complex mental health needs and are particularly vulnerable to environmental and communication stressors in closed settings. Whilst the review underscores the need for operationalisation of culturally sensitive health and wellbeing supports for migrants in prisons and immigration detention settings, it is recommended that States reduce their reliance on detention.

***Key Words*:** Migrant, health, Europe, prisons, detention

Introduction

Migration patterns and populations have become increasingly diverse in recent times. The International Organization for Migration (IOM, 2018) 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*". Migrants currently account for upwards of 258 million people – a twofold increase since 2000 and threefold since the 1970s (Douglas et al., 2019). With regard to Europe, a significant increase in migrant flow has been observed since 2014 (Geddes & Scholten, 2016; Lindert et al., 2008; Rechel et al., 2013). Frontex, the European Border and Coast Guard Agency, has estimated that over 1.83 million people entered the European Union (EU) in 2015. Since 2015, with the so-called "*refugee and migrant crisis*" (UNCHR, 2015, p. 1), the EU has been dealing with increasing numbers of asylum seekers. The crisis has been described as the biggest mass movement of people since the end of World War Two (Horyniak et al., 2016). Many are fleeing from the trauma of conflict, political tensions or terrorism, and the repercussions of severe poverty and displacement (Horyniak et al., 2016); (Van Hout et al., 2016). Source countries are from the Middle East (principally from Syria, Iraq and Afghanistan), and other parts of the World (Pakistan, Nigeria, Eritrea, Somalia and Sudan). The rapidity and social impact of this mass population movement combined with racial and cultural differences with the host European populations is changing European society and politics (Aiyar et al., 2016; Heltz, 2016). EU initiatives such as the EU Turkey deal and EU Measures to curb migration from Libya have led to some reduction in irregular migration.

Anti-immigration governmental groups however do politicise the health risks that newly-arrived migrants pose on host countries with an aim to fabricate a '*climate of fear*' encompassing migration (Abbas et al., 2018, p. 6). Upon arrival into host countries however

evidence shows that migrants in general have good health, a hypothesis referred to as the *'healthy migrant effect'* (Rousseau & Frounfelker, 2019). This is speculated to be due to the broad definition of migrant, and includes economic migrants, most often young men in good health seeking employment (European Commission, 2018). With regard to importation of infectious disease, the European Centre for Disease Control and Prevention (ECDC) has stated that "*newly-arrived migrants and refugees do not represent a significant risk for EU populations with regards to communicable diseases*" (ECDC, 2018, p. 1). For example, a significant proportion of migrants and refugees living with HIV in Europe acquired infection after arriving in the host country (WHO, 2018), likely a result of their vulnerability to risk (Arie, 2019; WHO, 2019). Migrants also appear to experience lower prevalence rates of several non-communicable diseases (NCDs) compared to host populations upon arrival, however their risk increases the longer they remain in these countries (WHO, 2018).

Prevalence of mental health problems (such as depression, anxiety, post-traumatic stress disorder) has however been found to be higher in migrants than in host populations, although prevalence shows a very high variation across studies (Close et al., 2016; Lindert et al., 2008; WHO, 2018). The unique vulnerabilities of those who flee conflict in their home countries, however, cannot be discounted. These vulnerabilities most particularly pertain to mental health and wellbeing, due to their exposure to exploitation, and experience of risk and poor living conditions during transit (Arie, 2019; Derose et al., 2007; IOM, 2018; WHO, 2019). Displacement, conflict related trauma, fear of human rights violations and personal security impact on their health, and particularly their mental health (Van Hout et al., 2016). A myriad of social and health related risks are encountered which are underpinned by transit and host environmental determinants of health, acculturation challenges and social and economic inequality (Van Hout et al., 2016). For those who encounter border controls, migrant holding camps in the EU have been found to be '*dangerous melting pots'* of inter-ethnic conflict, sexual

assault, violence and crime (Van Hout et al., 2016, p. 13). Anxiety and other psychological disorders can manifest due to post-migratory stressors like separation anxiety and uncertainty (Hameed et al., 2019). Despite these recognised observed vulnerabilities to deterioration of their mental and physical health, EU wide migrant health monitoring and health care approaches vary in terms of coverage, access, uptake and retention of migrant in health care (Mladovsky et al., 2012; Rechel, 2011). Restricted or interrupted access to medical care, lack of economic and social empowerment, language difficulties, and lack of cultural sensitive health services in the EU host country compound health vulnerabilities and subsequent adverse health situations for migrants (Spiegel & Golub, 2014).

Security concerns centre on how migrant smuggling routes crisscrossing Africa and the Middle East are embedded in criminal networks flourishing in North Africa and Southern Europe (Van Hout et al., 2016). Anecdotal and media reporting indicates that Syrian and Western European crime syndicates are not only implicated in facilitating migrant escape from conflict zones and migrant camps from the Middle East to Europe, but also in the coercion of migrants to commit crime on entry into Europe. Additionally, individuals of "*national, ethnic, religious or linguistic minority groups*" are persistently discriminated against in EU criminal justice systems, and as a result have an increased chance of being detained, charged and incarcerated for longer than the rest of the population (Rope & Sheahan, 2018, p. 16). Paralleling the notable increase of migrant flow via trafficking and legitimate channels into Europe is the concomitant increase and diversity in prison and immigration detention populations (Banks, 2018; Rope & Sheahan, 2018; Ugelvik, 2017; Walmsley, 2003). This has contributed to an observed *"superdiversity, multiculturalism and multilingualism"* in such closed settings (Gallez, 2018, p. 738) creating unique challenges to the operation of both prisons and immigration detention settings (Kalengayi et al., 2015). Many are detained not because they have committed a crime, but because of lack of certainty over their immigration

status, with EU Member States differing in terms of holding migrants in specialised immigration detention settings (e.g. United Kingdom; UK) or in prisons (e.g. Italy) (Van Hout et al., 2020). In light of this, Penal Reform International has underscored the need for specific monitors to clearly distinguish between people being detained on the basis of their immigration status (immigration detention) and those who have committed a crime (foreign national prisoners) (Penal Reform International; PRI, 2016).

It is crucial that migrant experiences of detention and incarceration are better understood in order to adequately and sensitively respond to their health needs and to ensure equitable access to health supports, both in prisons and in immigration detention settings (Grove & Zwi, 2006). We conducted a scoping review to map and describe extant literature on what is known about migrant health experience and unique support needs in European prisons and immigration detention settings.

Materials and Methods

Scoping review methodologies have become a progressively favoured approach across a variety of disciplines in recent years (Daudt et al., 2013; Levac et al., 2010; Munn et al., 2018; Pham et al., 2014). They are useful when a topic has not been extensively reviewed (Landa et al., 2010) (as was the case for this unique review) in order to provide a comprehensive descriptive overview of extant information across a wide range of sources, designs and methodologies (Arksey & O'Malley, 2005; Daudt et al., 2013; Levac et al., 2010). This approach has also been used successfully in scoping reviews on prison health situation in Africa (Van Hout & Mhlanga-Gunda, 2019; Van Hout & Gunda, 2019; Van Hout & Mhlanga-Gunda, 2018).

We adhered to the scoping review methodology (Arksey & O'Malley, 2005), an iterative 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 review process commenced with the establishment of the team, who have medical, public and prison health, migration, human rights expertise, and who have extensive experience in undertaking prison and migrant health evaluations. The underpinning research question was: *'What is known about migrant health experience and unique support needs in European prisons and immigration detention settings since commencement of the European migrant crisis?*' We adopted the broad definition of "*migrant*" (economic, forced, voluntary, etc.) (IOM, 2018). The terms "prison" and "detention settings" were defined as representing facilities housing both on-remand migrant prisoners (including jails, holding cells/centres and immigration detention centres) and convicted foreign national prisoners (FNP) in the EU. Detailed search terms were generated and combined using Boolean terms as such: (migrant* OR immigrant*) AND (health* AND policies OR guidelines OR services) AND (prison* OR jail* OR detention* AND Europe* OR Austria* OR Belgium* OR Belgian) – in order to produce a wider scope of findings. See **Table 1.** These terms were combined with '*Europe*' and the specific European countries/Member States**.** See **Table 2.**

Insert **Table 1 - Comprehensive Search Terms** about here

Insert **Table 2 - 28 EU Member States** about here

Following an initial exploratory search conducted by the lead author, comprehensive searches were conducted in the following databases; Web of Science, MEDLINE, PsycINFO, CINAHL, and Scopus (Boland et al., 2017). Searches were conducted in late 2019 using Liverpool John Moores University's electronic library, and restricted to peer reviewed studies in the publication timeframe of 2014-2019 (the timeframe of the European migrant crisis),

English language and the geographical context of the 28 EU Member States during that timeframe (UK was included). Reference lists were also manually searched by the team to identify any relevant studies not retrieved.

Records were managed using the bibliographic software manager EndNote, with duplicates removed manually. The title and abstract were screened by the lead author, and where any doubt remained in terms of inclusion authors two and four reviewed the record. Eligibility criteria for inclusion centred on whether the study referred to migrant health experience, health situation and identified unique support needs in European prisons and immigration detention settings in the timeframe since 2014. **Table 3** presents both inclusion and exclusion criteria using *PICo* as a framework.

Insert **Table 3 - Inclusion and Exclusion Criteria using *PICo* Framework** about here

All records deemed relevant following this screening were procured for review of the full text version. A second screening was conducted by authors two and four to ensure that records were relevant to the review question. Records were excluded at this stage if found not to meet the eligibility criteria. See **Figure 1.**

Insert **Figure 1 – Flowchart** about here

Following application of exclusion measures, fifteen records were charted as per (Levac et al., 2010) and thematically analysed. This process involved charting record details (author; journal; year of publication; location; method and aim; sample characteristics; data collection and analysis approaches; key findings and conclusions) using a spreadsheet, and identification of commonalities and themes in the findings. This was supported by a trial charting exercise in order to ensure consistency, develop prior categories and subsequent extraction of data (Daudt

et al., 2013). All records were charted and analysed in consultation, with disagreements around theme allocation resolved through team discussion. To avoid imposing pre-existing frameworks onto the data, themes were developed using line-by-line inductive coding. Three themes emerged from the analysis, with higher level abstraction centring on the overarching impact of communication barriers contributing to fear, confusion, isolation, lack of systemic trust and the ability to make informed decisions, and ultimately contributing to worsening mental health in migrants when detained.

Results

The review revealed a limited peer reviewed evidence base (n=15) pertaining to the health situation of migrants detained or incarcerated in Europe since 2014. The majority of the literature referred to the UK (n=7) (Arshad et al., 2018; Dexter & Katona, 2018; Hollis, 2019; Sen et al., 2018; Sen et al., 2014; Smith, 2017; Till et al., 2019). Of the eight remaining: three were based in Sweden (Puthoopparambil, Ahlberg, et al., 2015a, 2015b; Puthoopparambil, Bjerneld, et al., 2015) one in Spain (Ruiz-García & Castillo-Algarra, 2014); one in Portugal (Santos et al., 2018); one at a Greek-Turkish border (Eonomopoulou et al., 2017); one in the Benelux countries Belgium, the Netherlands and Luxembourg (Puthoopparambil & Bjerneld, 2016) and one referred to the EU as a whole (Mulgrew, 2016). There were five qualitative studies using interviews (Arshad et al., 2018; Hollis, 2019; Puthoopparambil, Ahlberg, et al., 2015a, 2015b; Ruiz-García & Castillo-Algarra, 2014); three review articles (Mulgrew, 2016; Sen et al., 2014; Till et al., 2019); two case studies (Puthoopparambil & Bjerneld, 2016; Santos et al., 2018); one feasibility study (Sen et al., 2018); one prospective study (Eonomopoulou et al., 2017); one correspondence (Smith, 2017); one cross-sectional study using a questionnaire (Puthoopparambil, Bjerneld, et al., 2015) and one editorial (Dexter & Katona, 2018).

Included records represented different populations with either direct experience as a detained migrant or as staff: foreign female prisoners (Ruiz-García & Castillo-Algarra, 2014); detainees in immigration removal centres (IRC) (Dexter & Katona, 2018; Hollis, 2019; Sen et al., 2018; Smith, 2017); pregnant migrant women in detention centres (Arshad et al., 2018); detention staff (Puthoopparambil, Ahlberg, et al., 2015a); FNPs (Mulgrew, 2016; Sen et al., 2014; Till et al., 2019); undocumented migrants in detention centre (Santos et al., 2018); newly arrived migrants in holding centres (Eonomopoulou et al., 2017); immigrant detainees, mostly refused asylum seekers, in immigration detention centres (Puthoopparambil, Ahlberg, et al., 2015b; Puthoopparambil & Bjerneld, 2016; Puthoopparambil, Bjerneld, et al., 2015) and staff and immigrant detainees in detention centre (Puthoopparambil & Bjerneld, 2016). Records were also diverse in terms of combinations of perspectives and focus; with four addressing experiences, conditions and health care access (Arshad et al., 2018; Hollis, 2019; Puthoopparambil, Ahlberg, et al., 2015b; Ruiz-García & Castillo-Algarra, 2014); five focusing on conditions and health care access (Dexter & Katona, 2018; Eonomopoulou et al., 2017; Santos et al., 2018; Sen et al., 2014; Till et al., 2019); five focusing solely on health care access (Mulgrew, 2016; Puthoopparambil & Bjerneld, 2016; Puthoopparambil, Bjerneld, et al., 2015; Sen et al., 2018; Smith, 2017); and one solely on experiences (Puthoopparambil, Ahlberg, et al., 2015a). The diversity of included records and subsequent findings illustrate how the vast majority of migrants were incarcerated or detained due to their migratory process and/or migratory transit related criminal activity (for example many, although they had trafficked drugs, were not drug users). We present illustrative quotes from qualitative studies where possible.

Theme One: Environmental determinants of health

Environmental determinants of health in prisons and immigration detention settings differed. In contrast to prisons, environmental conditions in immigration detention settings

were described in some publications as particularly sub-standard and potentially breaching the human rights of migrants (Dexter & Katona, 2018; Hollis, 2019; Mulgrew, 2016; Smith, 2017; Till et al., 2019). Immigration detention centres in Sweden, Portugal, Greek/Turkish border, and in the UK were described as overcrowded, unsanitary, unsafe and lacking in adequate nutrition, safe drinking water, privacy and access to health supports (Eonomopoulou et al., 2017; Puthoopparambil, Ahlberg, et al., 2015b; Santos et al., 2018; Till et al., 2019). The presence of mental health problems appeared to be particularly and adversely impacted by such detention conditions (Arshad et al., 2018; Hollis, 2019; Sen et al., 2018; Sen et al., 2014; Till et al., 2019).

Despite entitlement to *"a nutritious diet that takes into account their age, health, physical condition, religion, and culture"* consisting of three meals a day with reasonable internals between them whilst detained (Council of Europe, 2013, p. 5), inadequate provision of food and poor quality of nutrition was described in two studies set in immigration detention centres and particularly impacted on pregnant or breastfeeding mothers (Arshad et al., 2018; Hollis, 2019). This was illustrated by a Pakistani woman in one study who said: "*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"* (Hollis, 2019, p. 80). A similar situation pertaining to adequate food supplies was found in Spanish prisons, where there was no alternative food provision for pregnant women (Arshad et al., 2018). Prisoners in Spanish prisons and detainees in UK immigration detention centres were also not allowed to keep food in their rooms, despite frequently expressing their hunger to staff (Arshad et al., 2018; Ruiz-García & Castillo-Algarra, 2014). One woman stated: "*I requested the manager to keep some food in my room because I get hungry at night… but they refuse… I was so upset… it is just food we are asking for—nothing else*" (Arshad et al., 2018,

p. 594). Similarly, in another UK immigration detention centre, a participant from Pakistan described: "*They never allow the food in the room…They just say no, it's rule. They couldn't give you food in the room*" (Hollis, 2019, p. 80)

Theme Two: Communication challenges, isolation and poor mental health

Communication difficulties were closely interlinked with poor mental health and the worsening of underlying mental health issues of migrants in prisons and immigration detention settings. High levels of mental health problems experienced amongst migrants were reported in thirteen studies (Arshad et al., 2018; Dexter & Katona, 2018; Eonomopoulou et al., 2017; Hollis, 2019; Mulgrew, 2016; Puthoopparambil, Ahlberg, et al., 2015a; Puthoopparambil, Bjerneld, et al., 2015; Ruiz-García & Castillo-Algarra, 2014; Santos et al., 2018; Sen et al., 2018; Sen et al., 2014; Smith, 2017; Till et al., 2019). Ten clearly acknowledged the severity of mental health needs of migrants, which were often undiagnosed prior to intake/committal, and unmet thereafter (Dexter & Katona, 2018; Eonomopoulou et al., 2017; Mulgrew, 2016; Puthoopparambil & Bjerneld, 2016; Puthoopparambil, Bjerneld, et al., 2015; Santos et al., 2018; Sen et al., 2018; Sen et al., 2014; Smith, 2017; Till et al., 2019). In six papers, unique mental health challenges relating to PTSD, depression, anxiety and other mental health problems resulting from past experiences were reported (Eonomopoulou et al., 2017; Hollis, 2019; Puthoopparambil, Bjerneld, et al., 2015; Santos et al., 2018; Sen et al., 2014; Till et al., 2019). Experiences of suicidal thoughts, self-harm and depression were common, as reported in five studies (Arshad et al., 2018; Hollis, 2019; Mulgrew, 2016; Sen et al., 2018; Sen et al., 2014).

A worsening psychological state was described as being linked to traumatic experiences, pre-existing mental health conditions, and migrants' vulnerability to the dynamics of prisons and immigration detention settings (Dexter & Katona, 2018; Mulgrew, 2016; Sen et

al., 2014; Smith, 2017; Till et al., 2019). Detainees in four studies described the incessant fear and insecurity experienced in immigration detention settings, abusive behaviour from staff, and the worrisome deficiency of mental health supports (Dexter & Katona, 2018; Hollis, 2019; Santos et al., 2018; Smith, 2017). This was observed to not only amplify pre-existing mental health conditions in some, but also create serious risks to the mental health of all inhabitants (Arshad et al., 2018; Hollis, 2019; Till et al., 2019). This was described in a UK study as: "*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*" (Hollis, 2019, p. 81).

Linguistic issues, desperation and confusion around detention and asylum procedures were observed to further compound mental health vulnerabilities (Hollis, 2019; Puthoopparambil, Bjerneld, et al., 2015; Puthoopparambil, Ahlberg, et al., 2015b; Ruiz-García & Castillo-Algarra, 2014; Sen et al., 2014; Till et al., 2019). Migrants entering detention in good health appeared to be losing their identities and searching desperately for ways to cope (Arshad et al., 2018; Hollis, 2019). Arshad et al. (2018, p. 594) described the continuous fear of one woman in a Spanish prison: "*I feel suicidal… I was scared for my baby… What's going to happen next*". Language and communication difficulties around legal issues were reported. A migrant in a UK immigration detention centre said: "*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, p. 79). A Moroccan woman in a Spanish prison said: "*For the women who don't speak Spanish, it's very difficult to communicate, to ask about things, procedures… legal problems, lawyers… I do not know how to do*" and a migrant from Angola described her experience upon entering the system as: ''*It was horrible,*

firstly because I didn't speak the language, and then because I found myself with strange people who I'd never expected to meet in my life'' (Ruiz-García & Castillo-Algarra, 2014, p. 594).

Theme Three : Inadequate health care

Migrants' experiences were predominantly characterised by lack of sufficient communication and clarity around their situation, professional negligence of their health and wellbeing, and challenges accessing suitable health care all contributing to isolation, poor mental health and the exacerbation of mental health conditions (Arshad et al., 2018; Dexter & Katona, 2018; Eonomopoulou et al., 2017; Hollis, 2019; Puthoopparambil, Ahlberg, et al., 2015b; Puthoopparambil & Bjerneld, 2016; Puthoopparambil, Bjerneld, et al., 2015; Santos et al., 2018; Smith, 2017; Till et al., 2019). Only one record explored the experiences of migrant inmates and detainees indirectly by reporting on staff perspectives (Puthoopparambil, Ahlberg, et al., 2015a)..

Across three qualitative studies, it was observed that migrants generally entered prison/immigration detention centres in good physical health (Arshad et al., 2018; Hollis, 2019; Ruiz-García & Castillo-Algarra, 2014). Despite WHO (2014) emphasising the importance of initial health screening and evaluation of migrants on committal/intake, inadequate and nonexistent screening and medical care was highlighted in two studies based in Sweden and the UK (Dexter & Katona, 2018; Puthoopparambil & Bjerneld, 2016). Interrupted health care was reported in Spain, where a Colombian inmate expressed: "*You have to fall ill on Tuesday, because the doctor comes on Wednesday… and if it's a public holiday, you have to wait until the following Wednesday*" (Ruiz-García & Castillo-Algarra, 2014, p. 595). Key barriers to adequate health care for migrants were described as: the limited availability of health professionals, and errors and delays in prescription and distribution of medicine (Arshad et al., 2018; Dexter & Katona, 2018; Smith, 2017).

In six studies set in immigration detention settings, unresponsiveness of authorities was observed (Arshad et al., 2018; Dexter & Katona, 2018; Eonomopoulou et al., 2017; Hollis, 2019; Puthoopparambil, Ahlberg, et al., 2015b; Santos et al., 2018). The lack of adequate health care, particularly of mental health services was reported in Sweden, Belgium, the Netherlands, Luxembourg, and the UK (Dexter & Katona, 2018; Eonomopoulou et al., 2017; Puthoopparambil, Ahlberg, et al., 2015b; Puthoopparambil & Bjerneld, 2016; Sen et al., 2018; Smith, 2017; Till et al., 2019). Eleven records however indicated that existing detention and prison systems were not equipped to deal with the complex mental health needs of migrant prisoners and that, as a result, their needs were most often unmet (Arshad et al., 2018; Dexter & Katona, 2018; Eonomopoulou et al., 2017; Mulgrew, 2016; Puthoopparambil, Ahlberg, et al., 2015a, 2015b; Santos et al., 2018; Sen et al., 2018; Sen et al., 2014; Smith, 2017; Till et al., 2019). Migrant lack of representation amongst mental health referrals within detention settings was suggested to be a result of a lack of trained staff, language barriers and lack of culturally competent care in the facilities in the UK, Sweden, Belgium, the Netherlands, and Luxembourg (Dexter & Katona, 2018; Mulgrew, 2016; Puthoopparambil & Bjerneld, 2016; Smith, 2017). For example, in Sweden, there were no mental health care professionals working in immigration detention centres (Puthoopparambil & Bjerneld, 2016). In five studies, failure to identify vulnerable migrant individuals with psychosocial impairment and complex health needs was identified as a particular concern, and caused by insufficiently trained staff in Sweden and the UK (Dexter & Katona, 2018; Mulgrew, 2016; Puthoopparambil, Ahlberg, et al., 2015b; Puthoopparambil & Bjerneld, 2016; Puthoopparambil, Bjerneld, et al., 2015). Furthermore, a lack of continuum of care following migrants' release was identified in two studies, namely in the UK and Portugal (Santos et al., 2018; Sen et al., 2014).

Discussion

The scoping review represents a unique and first step towards mapping and describing extant literature on migrant health experiences and unique support needs in European prisons and immigration detention settings since 2014. The review was thorough in terms of its approach but was limited by virtue of the restriction of language (English) and to peer reviewed publications. We recognise that expanding the search to all European languages and to grey literature could yield additional EU/international organisational, and country level information pertaining to migrants that are detained or incarcerated. We include where possible English grey literature in our discussion of findings. The scarcity of peer reviewed studies available on the health experiences of migrants when detained or incarcerated in the EU, however, gives some cause for concern, and is perhaps indicative of a lack of academic focus on the issue or inherent difficulties in accessing prisons, immigration detention centres and other closed settings where migrants are held.

In protecting human rights of migrants in detention, there is a growing critical need for countries and international communities to "*devote greater attention and commitment to upholding the human rights of migrants*"(Acer & Goodman, 2010, p. 507). This particularly appears to be the case in immigration detention settings, where environmental determinants of health appear to be particularly grave. We recognise that migrants in some studies may not have expressly commented on conditions of detention because communication around immigration status, access to legal resources and language barriers were more prevalent concerns. It is evident that specific health provisions and visitation rights in European prisons are dedicated to FNPs (Raffaelli, 2017). In immigration detention settings, authorities also have a responsibility to safeguard detainees' health and wellbeing (Puthoopparambil & Bjerneld, 2016; UNHCR, 2012). Empirical and grey literature have however consistently reported how the close setting environment impacts negatively on migrant health and wellbeing (Amnesty

International, 2016; Barberio, 2018; Huber et al., 2017; Human Rights Watch, 2016; MSF, 2014, 2018, 2019; Prais & Sheahan, 2019; PRT, 2018; WHO, 2018). We know that prison overcrowding has undoubtedly increased in Europe in recent years (García-Guerrero & Marco, 2012; Prais & Sheahan, 2019; Warmsley, 2005) and has been found to have a greater detrimental impact on vulnerable groups such as migrants (Human Rights Council, 2017). Congested environments exacerbate the mental health of those detained or incarcerated (Goomany & Dickinson, 2015; Hazelwood, 2018; House of Commons, 2018; WHO, 2014), causing high levels of distress, security fears, tensions between staff and those detained, and even self-harming among vulnerable individuals (Criminal Justice Alliance, 2012). Qualitative studies in the UK have illustrated the concerning interplay between the environment and adverse mental health in migrant detainees and prisoners (Arshad et al., 2018; Hollis, 2019).

Migrants are entitled to the "*same universal human rights and fundamental freedoms as all persons, which must always be respected, protected and fulfilled*" (Abbas et al., 2018; WHO, 2018, p. 2). WHO, at the second Global Consultation on Migrant Health, acknowledged that the health needs of migrants have not been consistently addressed and that they often lack equitable access to adequate health services (IOM, 2017). Adequate health services for those detained remain mandated under the Universal Declaration of Human Rights, the United Nationals Committee on Economic, Social and Cultural Rights, the Nelson Mandela Rules[1], 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 (see also The United Nations Standard Minimum Rules for the Treatment of Prisoners, (UNODC, 2015)). Whilst acknowledging and further illustrating the complexity and uniqueness of migrants' health needs, particularly mental health, this review demonstrates insufficient consideration of their

[1] *Rule 2* of the Nelson Mandela Rules states that to put the principle of non-discrimination into practice, prison officials shall have regard to the individual needs of prisoners, specifically the most vulnerable. *Rule 24* declares that provision of health care for prisoners is a State responsibility and that prisoners should enjoy the same standards of health care as those accessible in the community.

unique health disparities. There appears to be an overall lack of cultural and linguistic sensitivity to their needs, and adherence and responsiveness to the existing screening and continuum of care guidelines (PRI, 2016; WHO, 2018). Although it appears that, upon arrival into the EU, migrants seem to be outwardly in good physical health, the review suggests that many are likely to be experiencing mental health conditions exacerbated by traumas, uncertainty around their immigration status, confusion due to communication barriers and absence of translated documentation, and subsequent lack of systemic trust and inability to make informed decisions.

It is recommended that States reduce their reliance on detention. Despite the small number of peer reviewed studies in our review, the results are indicative of the need for further strengthening of the provision of culturally sensitive health care services and competent mental health workers, specialised in migrant health, within prisons and immigration detention centres. The complexity of migrants' needs, based on their prior migration experience, language, medical histories and unique vulnerability to mental health conditions cannot be underestimated. The review whilst small scale, illustrates the impacts of '*superdiversity* ' and related challenges posed by multiculturalism and multilingualism in FNP and immigration detention populations (Gallez, 2018; Kalengayi et al., 2015). It is clear that attempts to deal with the issue of migrants' health needs and rights in European prisons and immigration detention centres is akin to tackling a moving target. If countries desire to improve public health it is critical that these settings respond to migrants' unique health needs, as without migrant health there is no public health (Rechel et al., 2013; Smith, 2018). A review of immigration detention guidelines that addresses language barriers, personnel training, and length of detention has been recommended (Puthoopparambil, Ahlberg, et al., 2015a). Increased academic focus and government level surveillance of migrant health both in closed settings and in the community is warranted.

Conclusion

Our review has illustrated the unique vulnerabilities of migrants when detained or when incarcerated in Europe. They have complex health needs, requiring mental health support, empathic staff, and culturally sensitive health care provision. Their situation is often compounded by communication difficulties and a lack of institutional trust leading to exacerbated poor mental health. The review highlights the need for reduced State reliance on immigration detention, further investigation, and collaborative working between security and health policy and practice to ensure culturally sensitive and mental health supports are implemented for those detained.

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Figure 1– Flowchart

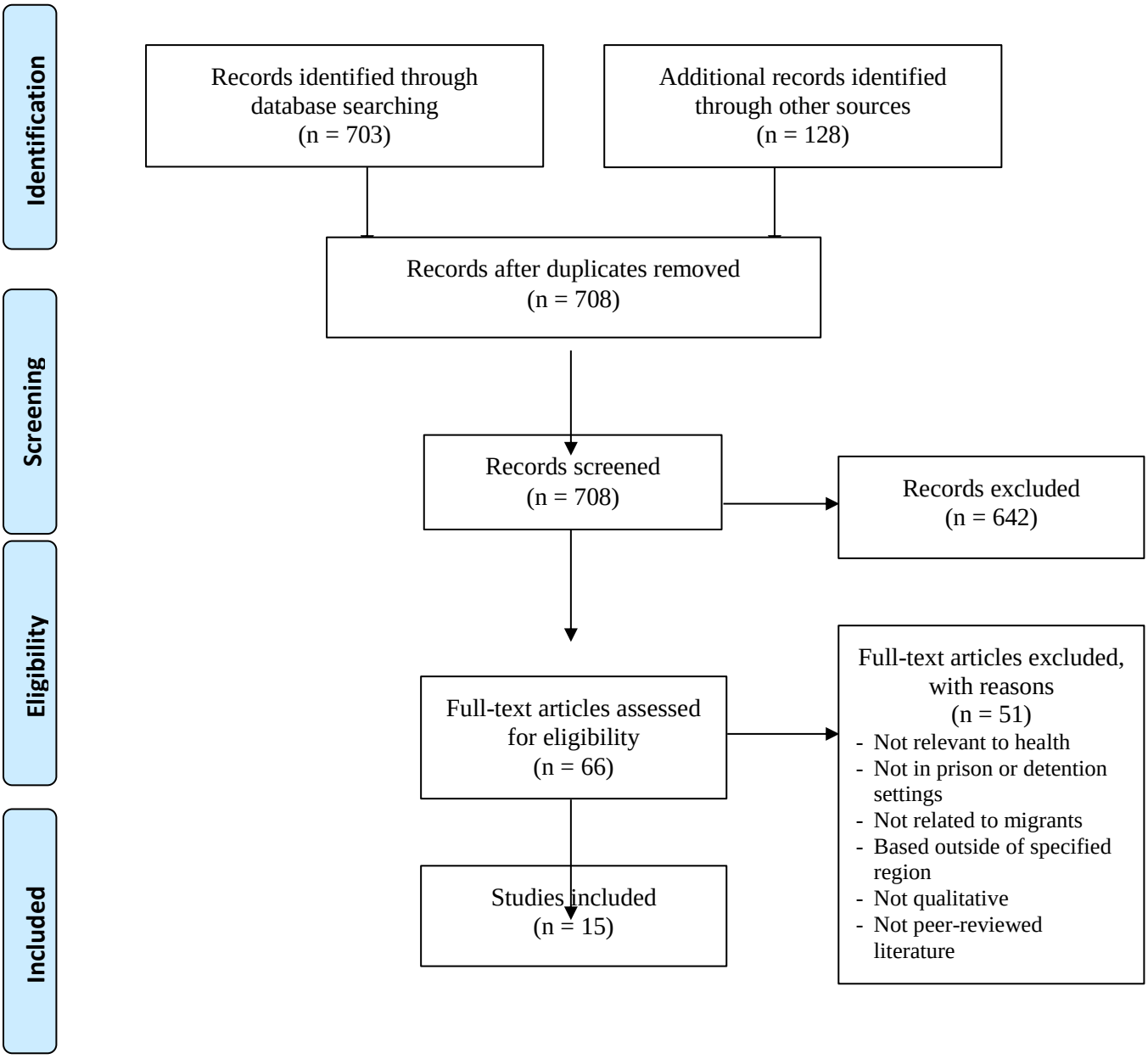

Table 1 ***Comprehensive Search Terms***

PICo concept	#	Search
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	(prison* OR jail* OR detention* OR incarcerat* OR custod* OR gaol* OR “correctional facility*” OR “correctional setting*” 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 2 ***28 EU Member States***

Austria	Estonia	Italy	Portugal
Belgium	Finland	Latvia	Romania
Bulgaria	France	Lithuania	Slovakia
Croatia	Germany	Luxembourg	Slovenia
Cyprus	Greece	Malta	Spain
Czech Republic	Hungary	Netherlands	Sweden
Denmark	Ireland	Poland	United Kingdom

Table 3 ***Inclusion and Exclusion Criteria using PICo Framework***

PICo element	Include	Exclude
Population(s)	• Populations considered and identified as any of the following: migrants; asylum seekers; refugees; transients; immigrants; emigrants; displaced individuals; foreign nationals • Professionals working with the above • Of any age • Of any gender	• Studies surrounding other population groups • Professionals not working with the above
Phenomena of **I**nterest	• Experiences relating to health • 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	• Studies that do not report health experiences relating to the specified population

Context	• Facilities housing both remanded prisoners and sentenced prisoners in any of the 28 EU member state countries • Facilities may include: prisons; jails; detention centres; holding cells; correctional facilities; immigration detention centres	• Facilities where populations are not detained and deprived of liberty • Facilities or settings outside of 28 EU member state countries
Research type	• Quantitative • Mixed methods • Any type of review (i.e. systematic, literature) • Qualitative • English language • Published between 2014-2019 • Peer reviewed	• Languages other than English • Published outside of specified timeframe • Not peer reviewed published literature

Table 4 ***Charted Records (Supplemental)***

AUTHORS	TITLE, JOURNAL/SOURCE, YEAR OF PUBLICATION	AIM	LOCATION	METHOD OF STUDY	RESULTS	CONCLUSIONS
PEER REVIEWED JOURNALS						
Ruiz-García, M and Castillo-Algarra, J.	Experiences of Foreign Women in Spanish Prisons, *Journal of Offender Rehabilitation*, 2014	Main objectives: (a) to establish the sociological and criminal profile of imprisoned foreign women in Spain; (b) to analyse prison life in general and, in particular, to examine foreign female inmates ' discourses and experiences	Prisons, Spain	In-depth interviews carried out with professionals. Discussion groups and interviews with female inmates	Key themes: Spanish language; relationship between foreign and Spanish women inmates; insufficient health care; different health demands; poor organisation of medical assistance; awareness and care of health; anxiety and anguish from not being able to take care of their children	Foreign inmates declared that in contrast to outside prison, there is no racism within the prison walls. Seemed that the process of institutionalisation implies that the status of prisoners overshadows nationality. Nevertheless there was tendency for ghettos to form amongst different nationalities. The sociological profiles of foreign and national female inmates are different, for example in terms of education, physical and psychological health. Generally, foreign women inmates were in better health than Spanish inmates, with a higher health education - making them more demanding about medical assistance in prison.
Hollis, J.	The psychosocial experience of UK immigration detention, *International Journal of*	To explore and analyse the phenomenology of entering, living in and coping with	Immigration Removal Centres, Scotland and England	9 in-depth interviews with participants that were recruited	Key themes: entering detention; life before detention; the shock of being detained; the powerlessness of detention; poverty of communication; negligence of	Following initial shock of detention, individuals felt powerless as a result of two main stressors (inconsistency and inadequacy of communications from immigration authorities & custodial

	Migration, Health and Social Care, 2019	life inside UK immigration removal centres. Particular focus on identifying psychosocial stressors in detention, psychological impacts these had on detainees, and how individuals coped with experiences and expressed resilience		through "Life After Detention" mutual-support group held weekly in Glasgow	health care; mental health impacts; resilience and coping in detention; coping styles; and relationships in detention	and medical staff neglecting physical and mental health needs). Six out of seven asylum seekers had limited English language proficiency which prevented them understanding basic information. Staff prioritised adherence to rules over basic human rights. Participants reported depression, anxiety and hopelessness. Most individuals in detention appeared susceptible to some emotional torment.
Arshad, F., Haith-Cooper, M. and Palloti, P.	The experiences of pregnant migrant women in detention: A qualitative study. *British Journal of Midwifery*, 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	Detention Centres, United Kingdom	6 in-depth interviews undertaken with four migrant women and two volunteer health professionals	Key themes: challenges in accessing maternity care; exacerbation of mental health conditions; feeling hungry; and lack of privacy	Antenatal care had been disrupted due to lack of midwives in detention centre. Midwives did provide appointments but not enough to match demand. A lack of continuity of care was found. All women interviewed had previously diagnosed mental health conditions which they felt was exacerbated due to circumstances. Volunteers stressed that detention staff did not recognise that mental health could deteriorate in detention and in pregnancy, and that women were ignored when expressing concerns about deteriorating mental health. Also discussed was inappropriate

						medication given, poor quality and quantity, and timings of food, and lack of privacy.
Puthoopparambil, S., Ahlberg, B. and Bjerneld, M.	"It is a thin line to walk on": Challenges of staff working at Swedish immigration detention centres, *International Journal of Qualitative Studies on Health and Well-being*, 2015	To explore and describe experiences of detention staff in providing services for immigrant detainees. Study is part of larger project aimed at identifying factors which could mitigate the effects of detention on the health and well-being of detainees in Swedish immigration detention centres	Three Immigration Detention Centres, Sweden	15 semi-structured interviews conducted with staff members (six females, nine males) including four supervisors, seven case officers, and four team leaders - in three Swedish detention centres. Interviews analysed using thematic analysis	Results indicated main challenge for staff was to manage 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.	Staff tried to manage dilemma by balancing the two roles, but still found it challenging. Among staff, there was high perception of fear of physical threat from detainees that made detention a stressful environment. Limited interaction between staff and detainees was a reason for this. 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 and detainees.
Dexter, E. and Katona, C.	Hunger strike renews concerns over health in UK detention centres, *BMJ*, 2018	To shed light on the inhumane living conditions in detention centres	Yarl's Wood immigration removal centre, Bedfordshire, United Kingdom	Editorial	On 21st Feb 2018, 120 women and men detained in Yarl's Wood immigration removal centre started a month's hunger strike to protest against conditions of detention. Demands included access to adequate healthcare and an end to indefinite detention policy. UK has	Her Majesty's chief inspector of prisons described conditions inside immigration detention centres as "prison-like". A 2016 report showed high number of deaths within UK immigration detention centres between 2000-2015 because Home Office & NHS England hadn't tackled systemic

					one of the most extensive immigration detention systems in Europe: only country within EU to have opted out of 28 day limit on detention, meaning people are held indefinitely (which harmfully affects mental and physical health).	failings in healthcare provision. Also identified: inadequate screening and medical care on arrival at detention facilities; failure to identify complex needs; lack of effective safeguards; substandard healthcare facilities. Conditions so awful that detainees go to extents of starving themselves in order to seek changes. It's clear that changes must be made as human beings are being held in inhumane, unfair & unacceptable conditions. In line with BMA's recommendations, medical profession must continue to support detainees and speak out against a system that's both harmful to health & fails to acknowledge and respect human rights of some of the most vulnerable people in UK.
Sen, P., Exworthy, T. and Forrester, A.	Mental health care for foreign national prisoners in England and Wales, *Journal of Mental Health*, 2014	To identify the FNP group as defined within prisons in England and Wales and examine current national understanding regarding the range and extent of mental health problems among them	United Kingdom	Review Article	Many FNPs face challenges: isolation (limited family contacts); language barriers; difficulties accessing services; prejudice and discrimination; active legal issues regarding immigration. All compounded by poor quality interpreting services, institutional barriers including racial assumptions propagated by forces of legislation, the disrupted local care pathways and common mental health problems (including PTSD, depression, anxiety). Pre-detention trauma, self-harm and suicide are over-represented.	Sources agree on 3 underlying core issues for FNPs: family contact; immigration; and language issues (often exacerbated by poor quality translated material and interpreting facilities). Strong established link between pre-migration trauma and mental health issues within refugee and asylum seeker populations, which may also apply with FNP groups. Very few studies specifically assess mental health needs of FNPs, those existing studies lack clear experimental design. There is an emerging body of evidence for use of diagnostic and treatment tools specific to needs of FNPs.

						Although literature in this area has yet to progress beyond an early level, it is possible that newly developed tools could assist service access by improving basic clinical assessments within this group through screening for common mental disorders. The article examined arrangements for provision of mental health care to FNPs and highlight specific difficulties when providing care for FNPs in England and Wales. National Delivery Plan clearly identifies need to improve access to disadvantaged groups, and human rights based approach to health care provision. Introduction of some relatively small & inexpensive projects, both research and service based, could assist in understanding and meeting particular needs of this group better.
Santos, G., Soares, C., Rebelo, R. and Ferreira, P.	Mental health and undocumented migrants in Portugal, *Journal of Public Mental Health*, 2018	To survey undocumented migrants (UM) attending a detention centre in Oporto (Portugal) to estimate the prevalence of mental health disorders in this population	Residential unit (RU) - temporary detention centre - Oporto, Portugal	Case study - a retrospective chart review was performed with relevant sociodemographic and clinical data of all UM in process of coercive removal from Portuguese territory, observed by	After exclusion of clinical charts without completed clinical information, 396 UM were considered eligible for study. 84% male, 76 months mean length of stay in Portugal before detention. 29% detainees diagnosed with mental and behavioural disorder. Female UM more prone to develop any mental and behavioural disorder. UM detention described as 're-traumatising environment', studies showing even brief period of detention adversely affects mental	Most prevalent mental health disorders either stress-related (associated with detention itself) or related to previous patterns of substance abuse. Overall it has been documented that most of the UM have no coverage for health care charges when they first arrive at the detention centres throughout Europe. Given study outcomes, it's highly recommended to mobilise human and technical resources to provide specialised mental health care to UM at least while detention policies could not be changed. Fundamental to stress

				Doctors of the World, during three years (2014–2016)	health outcomes. Literature reports length of stay is key factor for wellbeing and important risk of mental health disorders, even years after resettlement. Together with duration and uncertainty, pre-existing trauma, pre-existing mental and psychical health problems, health care and mental health care services availability and lack of activity in detention have been identified as central causes of mental distress.	that majority suffered from no mental illness as they utilised resources and coping mechanisms to deal with considerable challenges encountered during detention process. Nevertheless, researchers reported high prevalence of mental health disorders in population, thus raising awareness for need of a mental health care multidimensional approach with diagnostic and treatment resources in detention centres. Until policies change, physicians have ethical duty to provide medical assistance to this vulnerable population. The medical profession also had role in educating governments and public about potential risks of imposing excessively harsh policies of deterrence on mental health of migrants.
Sen, P., Arugnanaseelan, J., Connell, E., Katona, C., Khan, A., Moran, P., Robjant, K., Slade, K., Tan, J., Widyaratna, K., Youd, J. and Forrester, A.	Mental health morbidity among people subject to immigration detention in the UK: a feasibility study, *Epidemiology and Psychiatric Sciences*, 2018	To explore whether it was feasible to conduct psychiatric research in such a setting. A secondary aim was to compare the mental health of those seeking asylum with the rest of the detainees	Immigration Removal Centre (IRC), South England	Feasibility study - Cross-sectional study with simple random sampling followed by opportunistic sampling. Data were collected through a structured, verbal interview using	101 subject interviewed from 27 countries, mostly India and Africa. Overall response rate 39%. 35% previously incarcerated, 31% reported currently having mental health disorder and 19% to previously having one. Most prevalent screened mental disorder depression (52.5%), personality disorder (34.7%) and PTSD (20.8%). 21.8% at moderate to high suicidal risk. Overall presence of mental disorder comparable with levels found in prisons. Numbers in each group too small to carry out	Study supports findings of other research demonstrating high rates of mental health problems in immigration detainees and high levels of vulnerability. In view of results suggesting high prevalence of mental disorders in IRCs, recommended is a national multi-site prevalence study of mental health morbidity to improve understanding of needs of detainees in such a setting. Such a survey is more likely to be successful with assistance of a representative from mental health in-reach service for initial approach to potential participants. Multi-site model

				six validated questionnaires.	further analysis. Overall 75% of sample screened position for at least one mental health disorder. Prevalence of depression higher than reported in prisons using same screening tool. Rates of PTSD lower compared to those in detention, but higher than one study of prisoners.	would also help ensure subjects consenting to take part are not missed, as detainee turnover is very high in IRCs. Also recommend that future research includes appropriate interpreting facilities and shouldn't exclude EU nationals, as sample would not be truly representative. Suicide attempts in IRCs are at an all-time high, attracting national headlines. Challenges around providing appropriate mental health care to refugees and asylum-seekers continue to be debated in psychiatric literature.
Eonomopoulou, A., Pavli, A., Stasinopoulou, P., Giannopoulos, L. and Tsiodras, S.	Migrant screening: lessons learned from the migrant holding level at the Greek-Turkish borders, *Journal of Infection and Public Health*, 2017	To describe common syndromes, the communicable disease profile and vaccination patterns in newly arrived migrants through a surveillance system based on medical records data as well as screening procedures	Holding Centre, Greek-Turkish border	Data were collected prospectively using one standardised form per patient including demographic information, civil status, and medical and vaccination history.	6899 migrants screened, 91% male and 85% of age 18-31. Only 2.5% received secondary care. Among 3930 migrants seeking medical care, 99 admitted to hospital for treatment; 460 referred for examination by psychologist; 12 admitted to psychiatric ward. Given continuous influx of migrants, living conditions couldn't reach WHO standards. Many pregnant female migrants (factor of vulnerability requiring specialised medical care), making situation more difficult. Need for psychological support very important. Overall, no major health problems detected. Because of living conditions in destination countries and limited access to health care, migrants become	The "healthy migrant effect "upon arrival reported in past has several implications related to TB screening, diagnosis and prompt treatment. Irregular migrants entering Greek borders generally in good health. Nevertheless, risk of spreading CDs is an important issue to consider among migrants at holding level due to severe overcrowding conditions. Therefore, there is a need to strengthen surveillance & implement harmonised screening procedures with aim of providing sustainable and good quality services focused on prevention and early treatment. Increasing influx of migrants through Greek—Turkish border observed over last few years. Results of this study revealed vast majority of tested migrants in good physical condition and presented

					gradually vulnerable to mycobacterial infections.	mainly with symptoms of common problems (e.g. upper respiratory infections); however, most required sustained psychosocial support due to psychological trauma of detention and severe overcrowding conditions. Countries should ensure the sustainability and quality of health care services, with a focus on prevention and early treatment of communicable diseases in this highly vulnerable population.
Smith, J.	Death, disease and indignity: serious health and human rights concerns persist in UK Immigration Detention Facilities, *Journal of Public Health,* 2017	To shed light onto the serious issue of persistent health and human rights concerns in UK Immigration Detention Facilities	United Kingdom	Correspon-dence	On 3rd Dec 2016, ~2000 activists protested the continued imprisonment of individuals in Yarl'sWood IRC. The latest deaths, and identification of complex notifiable diseases, remind us that meaningful engagement with health protection and promotion of human rights has been suppressed in UK immigration policy. Such deaths also contribute to claims that private service provision has failed to meet the complex health needs of detainees. Latest report from Yarl's Wood's IMB raises concerns related to ongoing detention of pregnant women, and those with mental health issues, also identifying many issues undermining the provision of health care, including: delays accessing a GP; 'staff attitude and demeanour'; and errors & delays in prescription and delivery of	In 2014, the UN Special Rapporteur on Violence Against Women was denied access to the facility, leading to calls for action to address an accountability deficit. Detainee testimonies, the IMB report, visits by the National Audit Office, and an unannounced inspection by HM Chief Inspector of Prisons (a month after the release of a damning undercover report from Channel 4), continue to catalogue a series of serious failures and human rights abuses. However, it is imperative that the gathering of testimonies and other forms of evidence feed into a sustained programme of academic advocacy. In the same way that the Faculty of Public Health rallied behind the movement to end child detention in 2009, a moral obligation exists to continue to challenge systems of inhumane detention both in the UK and overseas. By drawing on health

					medication. Despite increase in incidence of self-harm in 2015 (96 reported cases, from 58 in 2014), and reports of anxiety, depression, suicidal ideation and episodes of acute psychosis among detainees, the provision of mental health services remains inadequate.	concerns, public health practitioners again have an opportunity to mount opposition to a system of detention that continues to obstruct the pursuit of health equity and social justice.
Puthoopparambil, S., Bjerneld, M. and Källestål, C.	Quality of life among immigrants in Swedish immigration detention centres: a cross-sectional questionnaire study, *Global Health Action*, 2015	To estimate quality of life (QOL) among immigrant detainees in Sweden and to assess its relationship with the services provided in detention centres and with the duration of detention	Five Detention Centres (Astorp, Gavle, Kallered and Marsta), Sweden	Cross-sectional questionnaire study	Mean QOL domain scores (out of 100) were 47.0, 57.5, 41.9, and 60.5 for the environmental, physical, psychological, and social domains, respectively. Level of support received from staff significantly positively associated with their physical and psychological scores. General health score was associated with ability to understand Swedish or English. Results suggest detainees were able to understand only half of information provided. Duration of detention also negatively correlated with QOL scores. Results show low QOL among immigrant detainees in Sweden. Level of support received and satisfaction with care were major explanatory factors associated with all scores. Other associated factors were detention duration and language barrier.	Results suggest that irrespective of detainees, services provided by detention staff affect their QOL. Thus, if improved, services have the potential to mitigate negative effects of detention on health & wellbeing of detainees. Immigrant detainees report low QOL. Services provided at the centres, especially support received from detention staff, is positively associated with QOL. A review of detention guidelines addressing language barriers, staff training, and duration of detention is highly recommended. Even in a country like Sweden, considered to have better detention standards, immigrant detainees have low QOL. As recommended by various international guidelines, detention of immigrants should be used as a last resort. If detained, duration of detention should be as short as possible, and ways of mitigating the negative effects of detention on health and wellbeing of detainees should be thoroughly explored. The findings of this study

						highlight the need for mitigation efforts in immigration detention centres to aim at minimising language barriers and in improving staff support and training to provide better services to detainees.
Puthoopparambil, S. and Bjerneld, M.	Detainees, staff, and health care services in immigration detention centres: a descriptive comparison of detention systems in Sweden and in the Benelux countries, *Global Health Action*, 2016	To describe and compare policies and practices that could affect the health and well-being of immigrant detainees in the Benelux countries (Belgium, the Netherlands, and Luxembourg) to those in Sweden	Detention Centres, Benelux countries (three in the Netherlands; one in Luxembourg; and two out of five centres in Belgium). Data used for Swedish detention centres were collected in previous studies.	Descriptive case study	Compared to Benelux countries, Sweden had limited health care provision available in detention centres. Swedish detention centres didn't have mental health care professionals working. Compared to Sweden, detention centres in Benelux countries had more relevant and trained staff. Sweden didn't offer entry/exit medical screening. If nurses visiting Swedish centres decided, detainees could be referred/taken to mental health professionals at local health centres. In Sweden, county councils where centres are located are responsible for providing health care services to detainees. In Benelux countries, health care providers are employed at centres or visit regularly (agreement with local hospitals). No country, except Belgium, provided any special training to health care professionals at centres. Access to health care at centres varied considerably between countries (detainees in Sweden had comparatively less access). Within EU, Sweden has very restrictive	Studies show that detainees suffer from mental illness and the need to offer mental health care is therefore evident. Despite Common European Asylum System framework, differences exist among the 4 EU member states in providing services to immigrant detainees. This study highlights these differences, thereby providing a window on how these diverse approaches may serve as a learning tool for improving services offered to detainees. In Sweden, health care available to detainees, and training and recruitment of staff should be improved, while Benelux countries should reduce restrictions within centres. Health care providers working in detention also need training to provide culturally competent care for varied needs of this specific group. Literature clearly shows health care providers with cultural competence as well as intercultural communications skills to be a critical factor in successful and appropriate health care interventions and patient receptivity to care. Clear communication is essential for identifying mental health issues

					health care provisions for asylum seekers and irregular migrants. Lack of access to adequate medical care in detention centres results in increased morbidity/mortality. Results show Benelux countries are taking steps to address detainees ' health needs, whereas Sweden is not.	since immigrants, depending on their culture, have different ways of expressing mental health concerns. Detainees 'inability to acquire and understand information related to their situation in detention has been shown to cause uncertainty and negatively affect their health and wellbeing.
Puthoopparambil, S., Ahlberg, B. and Bjerneld, M.	"A prison with extra flavours": experiences of immigrants in Swedish immigration detention centres, *International Journal of Migration, Health and Social Care*, 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 wellbeing of detainees.	Three detention centres, Sweden	Qualitative research design using semi-structured interviews (with 22 detainees)	Detainees likened immigration detention to imprisonment and 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. The perceived lack of control forced them into passivity. Differences in amenities provided were observed and some were reported to help make detention more bearable. County council where centre is located is responsible for providing health care services to detainees. Health conditions which cannot be deferred (emergencies) should be attended to. Three themes: stressors in detention, controlled by system and forced into passivity - which described stressors experienced by detainees who likened detention to prison as it created a sense of lack of control. Detainees known to have mental and physical illness, indicating need for increased	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, reduce the feeling of imprisonment, and thus mitigate the effects of detention on health and wellbeing of detainees. Alternatives to detention must always be pursued before resorting to immigration detention. However, if states deem detention necessary, it is important that the health and wellbeing 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 wellbeing. In order to mitigate the effects of detention on detainees 'health and wellbeing, health care provision at detention centres should be improved, arbitrary

					availability and accessibility of health care services. In Swedish centres, there was a lack of health care services, especially mental health (of concern considering confined living space, stressful situation and denied requests for hospital appointments by detainees).	restrictions in detention should be avoided and staff-detainee interaction should be improved.
Mulgrew, R.	Foreign Prisoners in Europe: an analysis of the 2012 Council of Europe Recommendation and its implications for international penal policy, *Review of International Law and Politics*, 2016	To analyse the penological and human rights implications of this recommendation in relation to its objectives to reduce the number of foreigners in custody, improve the regime experienced by foreign offenders and enhance the prospects for their successful reintegration	N/A	Review Article	Steps should be taken to ensure foreign prisoners (FPs) receive equivalent medical care to nationals and that health care professionals are trained and provided with resources to work with specific needs of foreigners. Recommendation urges that people working with FPs should be selected on basis of their cultural sensitivity, interaction skills and linguistic abilities. Moreover, all authorities, agencies, professionals and associations should receive training on relevant rules, underlying cultural and ethical bases for appropriate treatment. All those working with FPs should receive training to ensure respect for cultural diversity, understanding of problems faced by such prisoners and to enhance their linguistic abilities. Specific training should be provided to staff involved in admissions process and medical and health care staff should be trained on specific diseases and conditions	2012 Recommendation concerning FPs has made a significant contribution to regional penal policy by advocating reductionist policies, regime improvements, enhanced reintegration programmes and specialist staff. Its provisions seek to prevent and reduce the de facto discrimination and isolation faced by many foreign offenders. Adopting a human rights approach, the Rec aims to ensure equalisation and individualisation of treatment of foreign offenders throughout criminal justice and penal process. Given this support, it seems that this could contribute towards the development of a more humane and rehabilitation orientated approach for foreign offenders throughout detention experience. This Rec also has the potential to influence international penal law, policy and practice through its impact on regimes international prisoners are subject to and assessment of such regimes by international inspectorates.

					which foreign prisoners may have and culturally appropriate methods of interaction. FPs are more likely to become isolated, thereby facing increased risks of mental health problems, self-harm and suicide.	
Till, A., Sen, P., Chaplin, L., Grange, E., Exworthy, T. and Forrester, A.	The mental health of foreign national prisoners, *Journal of Forensic and Legal Medicine*, 2019	To shed light onto the difficulties relating to mental health faced by foreign national prisoners	N/A	Review Article	Within general prison population, significant health disparity exists compared to society at large: prisoners have much higher levels of physical/mental health disorders. It's increasingly recognised that existing prison systems are poorly equipped to manage the diverse set of issues presented by FNPs, and therefore improvements are recommended by many (inc. governmental and non-governmental organisations and researchers), keeping with UN guidelines stating prison systems are obliged to ensure practices don't "aggravate the suffering inherent in such a situation". Meanwhile, research info regarding levels of mental health morbidity amongst FNPs is limited. Work done, however, indicates that they suffer from higher morbidity rates than general prison pop. Generally, literature indicates FNPs are more likely to harm themselves and die by suicide than general prison pop. 3 major contributing factors: language barriers, difficulty	There is emerging evidence that FNPs access clinical services less than should be expected given their high levels of unmet need. Compounding this inequity further, the ability of services to understand, diagnose and manage the complex health needs of FNPs could contribute to an exacerbation of ill health and be improved in many areas. The right to health encompasses access to appropriate health care independent of legal status and, as with all human rights, extends to FNPs. Evidence tells us that change is required, and there should be a public health imperative to provide improved health services for FNPs to address the high burden of health need–or the so called "vertical equity" in health care services, where 'enhanced health services are provided where greater health needs are present'. Formal recognition of this group's marginalisation and concerted efforts, both through research and service pilots, to identify these areas of greater need, could assist policy-makers in understanding how best to improve and restructure existing health

					maintaining family ties, and immigration concerns.	care services for the benefit of this population.