

Addressing the health challenges in immigration detention, and alternatives to detention

A COUNTRY IMPLEMENTATION GUIDE



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Abstract

This country implementation guide outlines current evidence, knowledge and best practices relating to the health and health challenges of refugees and migrants in immigration detention, as well as alternatives to detention. It highlights key principles and international commitments, summarizes the current status and health challenges and provides practical considerations for addressing the health challenges of refugees and migrants in immigration detention, as well as the implementation of alternatives to detention. Specific areas for intervention include providing comprehensive training for staff, ensuring safeguards, providing psychological support and providing tools to prevent the spread of communicable diseases. The guide also promotes engagement-based alternatives to detention. While the main intended audience is policy-makers across sectors at local, national and regional levels, the guide is also of value for health planners, relevant ministries, international organizations, management of immigration detention facilities and their staff, and researchers.

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Abbreviations and acronyms

ATD	alternatives to detention
CAP	community assessment and placement (model)
CPT	Committee for the Prevention of Torture (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment)
EU	European Union
ID	immigration detention
IDC	International Detention Coalition
IOM	International Organization for Migration
NCD	noncommunicable disease
NGO	nongovernmental organization
PTSD	post-traumatic stress disorder
SOGIESC	sexual orientation, gender identity, gender expression and sex characteristics
TB	tuberculosis
UNHCR	United Nations High Commissioner for Refugees
WGAD	United Nations Working Group on Arbitrary Detention

Executive summary

Immigration detention (ID) in this guide focuses on facilities in which refugees and migrants experience the full deprivation of liberty (regardless of the label given to these facilities) in relation to migration-related proceedings. Most often ID is considered an administrative procedure, although some countries have criminalized irregular migration, which can lead to ID. International law clearly states that ID should only be used as a last resort and never for children; however, it has seen increasing use as a tool to manage migration flows in the WHO European Region over the years.

The health of refugees and migrants is essential for overall public health and is also important from a human rights perspective. ID facilities do not stand in isolation and the staff working within them are also at risk for any health concerns. Research has shown the negative impacts of full deprivation of liberty on the health of individuals; these effects may be seen also in migrants in ID in the WHO European Region.

There is no standard definition of what constitutes alternatives to detention (ATD) although they are often considered to be policies or programmes that provide migrants who otherwise would have been detained with the opportunity to instead reside within the community to complete migration procedures. All measures considered should only be put in place after assessing the situation of the individual migrant. However, this happens infrequently in the Region. Until recently, ATD has not been widely used, even though many countries have legal provisions to do so. Efforts by international agencies and local nongovernmental organizations (NGOs) to expand the implementation of ATD and reduce the use of ID have been ongoing for many years.

ID varies widely across the Region and often within Member States themselves. The maximum length of ID often ranges from six to 18 months, although in rare cases there may be no legal limits on the maximum duration. It is often described as prison like, both in relation to the physical structures in use and in the restrictions and amenities available to migrants.

While globally both refugees and migrants might be detained for migration-related matters, studies that were reviewed to form the evidence base for this guide did not include any results on refugees in ID. This does not mean that refugees might not be detained for immigration-related matters; however, the current evidence review did not find evidence to support this. Although the studies reviewed for this analysis refer to migrants as the population of concern, the discussion and recommendations in this guide are relevant for both refugees and migrants.

It is challenging to draw a representative and comprehensive overview of the health of migrants in ID because of the limited research that has been conducted on the topic. The majority of studies have focused on the mental health impacts of ID. Findings show that, regardless of the country context, the environment in ID can cause a decline in the mental health of migrants. The longer migrants are detained, the worse the effects are on their mental health. These negative impacts can be long lasting, even after release. The conditions in ID also place migrants at risk from communicable diseases, violence and traumatic events. The general health status of migrants in ID upon arrival is comparable to that of the local population. However, many migrants rate their quality of life in ID as low and their physical health as poor, and this worsens as the

duration of ID increases. A multitude of stressors exist within ID, including the uncertainty of migration proceedings, being treated like a criminal, feelings of isolation, lack of support from staff and communication barriers.

Although ID is often an administrative measure, it is frequently compared with prisons by migrants and researchers. In comparison with prisons, ID often offers limited safeguards and services. Evidence indicates that migrants in ID have the same or worse mental health outcomes compared with people living in prison. The regime in ID dictates the freedom that migrants have to move about the facility and access amenities.

The health provision in ID also fluctuates between facilities. Although many countries have domestic laws that dictate the health-care services available to migrants in ID, they are often ambiguous or interpreted differently between facilities. The majority of facilities provide access to essential medical care. Although the mental health needs of migrants in ID are well documented, psychological care is often missing. Interpreters are rarely employed, creating challenges in accessing care and receiving quality health care. Other challenges for accessing health care include the availability and competencies of health-care providers, mistrust, poor medical records and the gatekeeping role of ID staff.

Staff in ID can either facilitate migrants' access to health care and support, thereby increasing their well-being, or can intentionally or unintentionally create barriers. Evidence supports the association between the support migrants received from staff and the migrants' psychological health. Members of staff often perform multiple roles at one time, undermining their professionalism and limiting their ability to create meaningful bonds with migrants in ID. Health-care personnel are often not trained to support the specific health-care needs of migrants in ID. They express concerns with balancing the dual loyalties of protecting their patients while complying with the obligations and processes of ID. Training for staff in ID in general is basic and if comprehensive training is offered at all it is often voluntary or infrequently available.

Interventions to mitigate the negative effects of ID focus on training staff, ensuring safeguards, psychological support and providing tools to prevent the spread of communicable diseases. Mental health measures include psychological support groups, ensuring staff support and encouraging migrant solidarity in ID. Programmes that integrate holistic medical teams (including physicians, nurses, cultural mediators, social workers and psychiatrists) within ID were found not only to help to meet the health-care needs of migrants but also to improve the environment in ID overall. There exists a multitude of guides on training ID staff, facilitating vulnerability screening and on procedures for monitoring conditions and treatment in ID. Finally, efforts to minimize the spread of communicable diseases are available through the use of mathematical modelling, with guides focusing on minimizing the spread of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in ID.

Community-based ATD should be considered during instances where some form of detention is considered necessary by authorities. Even if ATD are better than ID, they may still restrict migrants' freedom of movement. Therefore, even a decision to implement ATD instead of ID should have a judicial basis. While no standard definition exists, ATD cover programmes that offer refugees and migrants who would otherwise be detained the opportunity to reside within the community and access casework support during migration procedures; sometimes ATD

include restrictions or obligations such as regular reporting or restricted movements within an area. Ideal options include case management-based approaches, focused on engagement instead of enforcement. Most importantly, these case management-based ATD are found to improve and protect the health and well-being of migrants. They also have been proven to be effective in the WHO European Region, with studies showing improved compliance (with migration proceedings), reduced risk for absconding and increased cost-effectiveness when compared with ID.

The Ottawa Charter for Health Promotion is used as a framework for the recommendations, which explore ways to alleviate the health impacts of ID across five themes: healthy policies, supportive environments, community action, developing personal skills, and appropriate health care (Section 4). Healthy policies include the better use and implementation of ATD with an aim for Member States to avoid ID whenever possible. If States do detain refugees and migrants, then Section 4.2 (Supportive environments) lists key standards to ensure that ID limits restrictions and provides an environment that enables the health and well-being of refugees and migrants. Community action calls for better collaboration between stakeholders, including regular monitoring of ID as a preventive measure to safeguard the health of refugees and migrants. The well-being of refugees and migrants is impacted by how supportive staff are in ID and, therefore, the developing personal skills section focuses on the requisite training staff need to receive to perform their duties with the needs of refugees and migrants in mind. Finally, the discussion on appropriate health care lays out the duty of care that States have to provide needs-based access to free medical care and the necessity of comprehensive medical screenings and incorporating psychological health care.

1. Introduction

KEY POINTS

- International law, guidelines and agencies consistently reiterate that ID should only be used as a last resort, and never for children.
- ID has become a vital part of migration management strategies in the WHO European Region, and in many cases usage has increased over recent years.
- Maintaining the health and well-being of refugees and migrants is essential for overall public health, and from a human rights perspective.
- ATD should always be considered as the first option.

1.1 What is ID?

The United Nations High Commissioner for Refugees (UNHCR) defines detention as, “the deprivation of liberty or confinement in a closed place which an asylum-seeker is not permitted to leave at will, including, though not limited to, prisons or purpose-built detention, closed reception or holding centres or facilities” (1). The European Union (EU) considers detention of refugees and migrants as a “non-punitive administrative measure ordered by an administrative or judicial authority(ies) in order to restrict the liberty of a person through confinement so that another procedure may be implemented” (2). Similarly, the International Organization for Migration (IOM) states that administrative detention is the “deprivation of liberty decided by the competent administrative authority of a State, whether it is subject to judicial review or not” (3). Although there are various definitions for ID, the common element in all definitions is the deprivation of liberty for refugees and migrants for migration-related proceedings (4). The Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (Art. 4 (2)) defines deprivation of liberty as “any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority” (5).

ID is often not considered a criminal procedure. However, there are instances where boundaries between criminal and administrative procedures are blurred in practice, and ID might be a result of irregular migration and the irregular status resulting from this; this might be criminalized within a country (4,6–9). Nevertheless, human rights mechanisms and international organizations strongly advise against the criminalization of irregular migration (1,10–12). In the context of ID, States often employ a variety of terms to describe these facilities, including immigration removal centres, detention centres, transit zones, holding centres, reception and identification centres, or prisons (13).

As a general guide, as stated by the United Nations Working Group on Arbitrary Detention (WGAD), “deprivation of liberty is not only a question of legal definition but also of fact. If the person concerned is not at liberty to leave, then all the appropriate safeguards that are in place to guard against arbitrary detention must be respected” (para 56, A/HRC/36/37) (14). The WGAD states that “[I]t is paramount that, irrespective of what such places are called, the circumstances in which an individual is detained are examined so as to determine whether he or she is in fact at liberty to leave such a place at will” (para 52; A/HRC/36/37) (14).

It must be held in mind that everyone, including refugees and migrants, is entitled to the right to personal liberty, which can only be curtailed in exceptional circumstances. Therefore, personal liberty is the principle and ID, representing deprivation of liberty, is an exception to that principle. As such, each use of ID must be justified as (i) prescribed by law; (ii) pursuing a legitimate aim; and (iii) necessary and proportionate. Otherwise, the use of ID may be arbitrary and breach Article 9 of the Universal Declaration of Human Rights (15), Article 9 of the International Covenant on Civil and Political Rights (16) and Article 5 of the European Convention on Human Rights (17).

For the purpose of this guide, the focus remains on facilities (regardless of the label given to them) that refugees and migrants are unable to leave without the approval of authorities.

The context of full deprivation of liberty as indicated above is the central focus, because research has highlighted its harmful impact on the health of migrants who are fully deprived of liberty in ID (18–24). The challenges, needs and measures to address the health of refugees and migrants in ID are the focus of this guide.

Refugees and migrants who are detained range across contexts and countries and are not easily categorized (25,26). However, they can be broadly classified into applicants for international protection (asylum seekers), and migrants who are staying irregularly in a country or have tried to enter a country in an irregular manner (26–34).

The Global Compact for Safe, Orderly and Regular Migration clearly lays out in its objectives that ID is to be used as a measure of last resort, that ATD need to be considered first and that children should not be detained (Objective 13) (35). This is also echoed in other guidelines and stipulations laid out by international agencies and international law (1,4,12,15,35–38). Further, the international legal position is that children should never be detained for reasons of their immigration status or that of their parent(s) (13,38–40). EU directives stipulate that ID should be based on set criteria and legal grounds dictated by individual nations and only used as a last resort (36,37). In theory, these documents present a unified front stating that ATD (which includes any law, policy or practice that gives refugees and migrants more freedom to reside within the community during migration proceedings; see section 3.6) should be considered first and ID only used as a last resort, although in reality ID is employed extensively in the majority of European countries (13) and is increasingly becoming a more widely used tool (41–49). The recent European Pact on Migration and Asylum (published September 2020 by the European Commission) cites ID as a major strategy for future migration management (50,51). The Pact highlights the concern regarding irregular migrants who abscond during the migration process or are a threat to public security, thereby initiating procedures and stronger rules that aim to prevent absconding by “allowing ID of irregular migrants who pose a security threat” (52).

Data on numbers in ID are sparse, not systematically collected, rarely disaggregated and often not comparable between countries, leading to gaps in knowledge and an inability to study definitive trends (13,27,41). From available data, ID seemed to decrease in the EU between 2009 and 2013 (by around 5%), with 92 575 individuals detained in 2013 based on data provided by 24 EU countries (27). The arrival of large numbers of refugees and migrants to Europe as a result of mixed migration flows during 2015 and 2016 may have contributed to an increase in the number of detained migrants and asylum seekers, which according to the Global Detention

Project and other sources continued across the WHO European Region long after the so-called crisis ended (43,53–56). The EU does not provide numbers on annual ID rates; however, there has been a decrease in asylum applications since 2015 (57), yet an increase in the total number of rejections of asylum claims between 2014 and 2019 (58). Furthermore, ID is enforced most often in the EU in relation to the return process (27). However, a more recent global study on children in ID provides a more mixed perspective. Despite international law, children are still detained for reasons pertaining to migration. Although some countries in the WHO European Region have reported a reduction in the number of children detained, others have reported sharp increases (13).

A multitude of legal, administrative and political strategies and tools are used to facilitate the flow and management of migration into Europe, of which ID is one (25,27,59). In some instances, ID may be used as a strategy and form of communication and deterrence, although there is no evidence to support the effectiveness of this strategy (60) or that it relays to prospective migrants the political climate in a country (59–61).

1.2 The importance of refugee and migrant health

The right to health is a fundamental right for all, including refugees and migrants (15,62,63). This has been supported by the Sustainable Development Goals, which promote leaving no one behind, with Goal 3 being health and well-being for all at all ages (64). Supporting the health of refugees and migrants is essential from a public health perspective, as access to health care supports better health outcomes, is economically beneficial and reduces the late presentation of diseases (65,66). The spread of SARS-CoV-2 and the resulting COVID-19 pandemic is a relevant example of the vulnerabilities experienced by refugees and migrants. Current data suggest that some refugee and migrant groups have been disproportionately affected by the pandemic (67–71). A multitude of factors are associated with this vulnerability, including crowded living conditions, poor working conditions, barriers to accessing health care, and greater income instability related to the pandemic (67–71). Such vulnerabilities may affect migrants in ID (see section 3.2.1). According to population estimates from the middle of 2020, international migrants, including refugees, make up approximately 11% of the population residing in the WHO European Region (72). Some subgroups in this population, such as asylum seekers, irregular migrants, victims of trafficking and others in vulnerable situations, are disproportionately affected by many communicable diseases and face an increasing risk for noncommunicable diseases (NCDs) the longer they live in a host country (65).

Risks for poorer health outcomes for refugees and migrants are related to policies enacted by host countries. These migration-related policies act as a vital social determinant of health that may directly impact health by creating barriers to accessing health care or more indirectly by affecting social and economic factors (73). Irregular migrants face many legal provisions across the WHO European Region that restrict access to health care (65,74). There is evidence that restrictive migration policies adversely affect the health of refugees and migrants, increasing the likelihood of self-rating health as poor, reporting more mental health symptoms and increasing mortality (73,75). Further, those more restrictive policies were associated with a decreased likelihood that migrants would utilize health-care services (73).

ID is a restrictive policy and tool that negatively impacts the health of refugees and migrants who are detained (22,24,76,77). The health of refugees and migrants in ID has a wider impact for the public health of the community, as ID does not exist in isolation. Staff provide a link with the wider community and are at risk from any health issues such as communicable diseases within the facilities and equally can introduce new health concerns into the facilities through proximity (78). Being in ID, deprived of liberty by the State, also creates an additional vulnerability for refugees and migrants and places a duty of care upon the State, which should address the health concerns of refugees and migrants in ID as part of the universal right to health (15). Understanding how this impacts health outcomes for refugees and migrants and, more importantly, how to address these challenges are essential in order to support the development of policies and practices that respect the human rights of all individuals.

1.3 The importance of discussing ID and ATD

Despite the existence of ATD (27,79), countries continue to use ID, and both the numbers of migrants in ID and the capacity of ID facilities has increased in many instances (41,43–45,51,53,54). Capturing the true annual numbers of people in ID has been mired by the varying classifications of ID in the WHO European Region, lack of disaggregate data and lack of data collection and availability on ID overall (13,25,27). This lack of data leads to gaps in knowledge and an inability to study trends (13,27,41). It does appear that there was a decrease in ID in the EU from 2009 to 2013 and then an increase in 2015 and 2016, reflecting the surge in mixed migration at that point. This increase has remained even though the numbers migrating have decreased (see section 1.1). However, a more recent global study on children in ID provides a more mixed perspective, indicating that some countries reported a reduction in numbers of children detained (80), while others reported sharp increases in the wider WHO European Region (13). In line with the global compacts, international guidelines and laws (1,5,35–37), it is vital that countries increase the implementation of ATD. ATD are not only required by international law and guidelines (1,36,37), they are essential to ensure the dignity and respectful treatment of all individuals.

This guide has been structured to provide evidence on the health status of refugees and migrants in ID within the WHO European Region. While globally refugees and migrants may be detained for migration-related matters, the documents identified in the search strategy (Annex 1) showed no clear evidence regarding refugees being detained for immigration-related matters. This does not mean that it never occurs, and this Introduction and section 4 on the way forward and measures for consideration discusses both refugees and migrants to emphasize that the guide is applicable to both. However, sections 2 and 3, which present the evidence found in the review, will only refer to the migrant population identified in the included studies.

1.4 Objectives of this guide

This report aims to provide tools and guidance, based on existing evidence, on how to address the health challenges related to ID across the WHO European Region. It examines the evidence base to:

- identify, describe and understand recent trends in ID use and management
- improve knowledge on the health and well-being of refugees and migrants in ID
- analyse health challenges, including disease prevalence, in ID
- enhance the availability of migrant health data in ID
- assist Member States to identify strategies to address the health of migrants in ID
- assist Member States to develop ATD.

Although other aspects such as the legality surrounding ID are important, it is beyond the scope of this document to discuss such aspects in detail. This document instead focuses on the health aspects of ID. Initially, evidence will be presented on ID practices in the Region, followed by evidence on health outcomes among migrants in ID. Evidence will also be presented on health-care provision in ID and the role of staff (general and health-care providers) and how these are related to both migrants' health and access to health care. An overview of potential strategies to address the health challenges faced by migrants in ID will be outlined. Finally, evidence on ATD will be shown alongside an overview of what is happening in the Region and how this impacts the well-being of migrants.

Section 4 will examine the way forward and offer considerations on how to apply measures and standards to ID to improve the health of refugees, migrants and staff. The Recommended reading includes further material, guides and standards that relate to the considerations outlined in the document.

The target audience for this guide includes those in policy-making roles at local, national and international levels: health planners; ministries of health; ministries of migration; ministries of justice and other relevant ministries; international organizations; researchers; management of ID; and other relevant stakeholders. While this guide specifically addresses the situation in the WHO European Region, the contents, with context-specific adaptations, may also be applicable for countries and regions outside.

1.5 Methodology

A scoping review was performed during July–August 2021 to gather both peer-reviewed and grey literature in English, Dutch, French and Russian. The search was performed to identify evidence on health and health challenges in ID, and measures to address challenges in the WHO European Region. Literature on the use of ATD and their impact on migrant health was also reviewed.

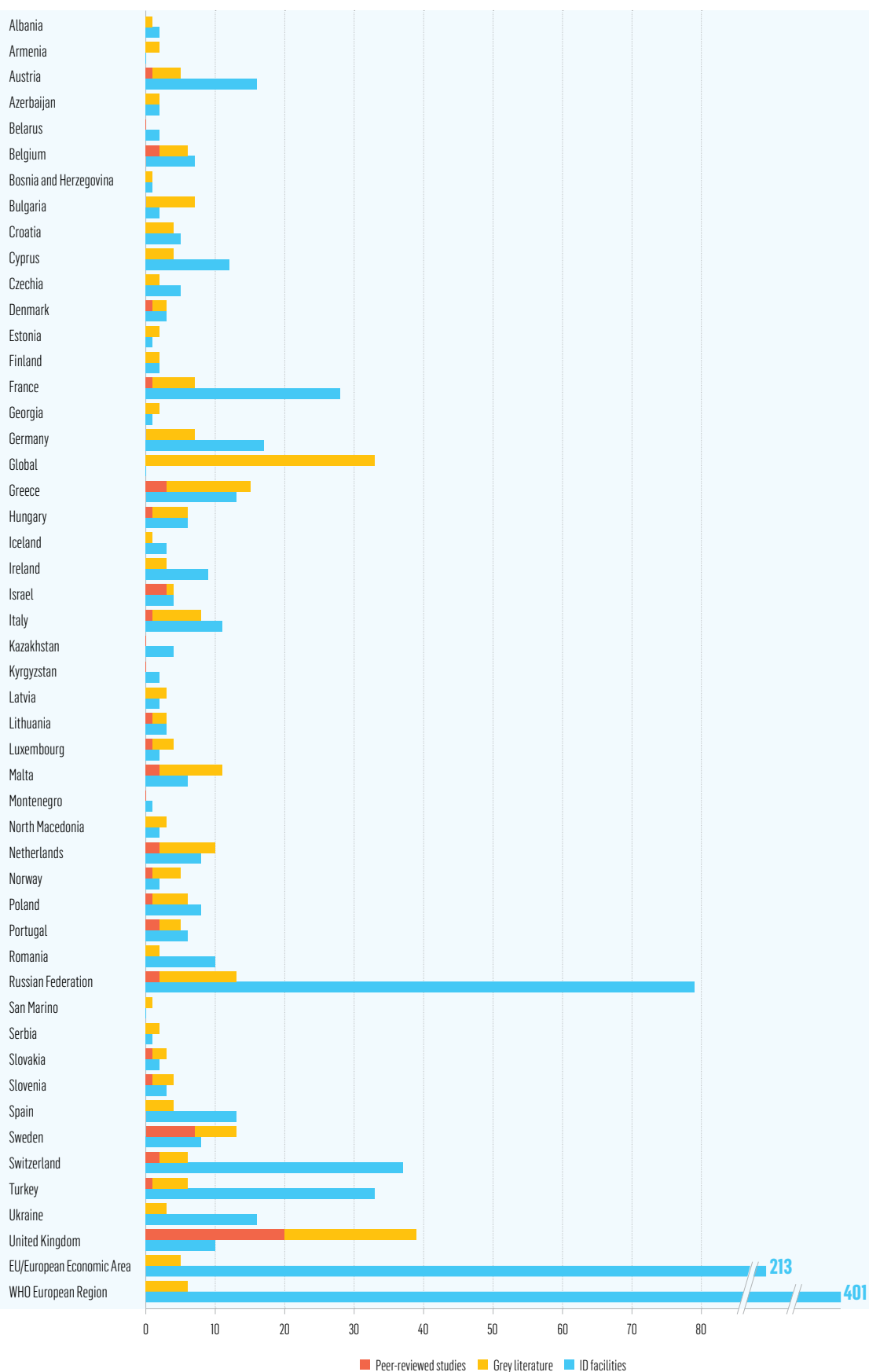
The peer-reviewed literature search identified 22 992 articles of which 32 studies were included for narrative synthesis. A further 10 studies were identified from the reference lists of the already included peer-reviewed review articles and grey literature reports, giving a total of 42 peer-reviewed studies. The grey literature search yielded 219 reports for inclusion in the final synthesis.

Annex 1 provides the full details on the methodology.

2. Overview

Fig. 1 shows the number of countries that have studies and reports published in both peer-reviewed and grey literature that examined health aspects of ID or ATD. Nine of the studies explored more than one country and these were counted as one study for each country involved. However, studies marked WHO European Region, EU or global were only counted once and were not entered into the country totals as the guidance they contained was often broad or it was unclear which countries specifically were in question. The number of studies and reports are shown in proportion to the number of ID facilities (anywhere in which migrants may be detained for ID purposes, which in some countries included prisons) within each country. The number of facilities were found on the Global Detention Project's database during October 2021 and so numbers will only accurately portray the situation at that point as reported by Global Detention Project. There were 194 facilities identified for the WHO European Region. A further 231 facilities were marked with "previous last documented use"; these have also been included, although they have not been independently verified since the date listed on the database. Facilities marked as temporarily closed (17) were not included; closure may be temporary during COVID-19 or for renovations.

Fig. 1. Number of reported ID facilities and number of studies (peer-reviewed and grey literature) identified for Member States of the WHO European Region



Note: some countries did not have data available to report and were therefore not included in the figure: Andorra, Monaco, Republic of Moldova, Tajikistan, Turkmenistan and Uzbekistan.

3. Findings

3.1 Overview of ID practices in the WHO European Region

KEY POINTS

- ID is often described as prison-like in relation to both the physical structures in use and the restrictions and amenities available to migrants.
- Regimes in ID can be considered open or closed; this refers to how freely migrants can move throughout the facility as well as access leisure and educational activities/spaces (such as outdoor courtyards, libraries or common spaces).
- Often migrants have access to outside communications through telephone calls, visitors (family, friends and NGOs) and access to the Internet, although it varies widely on when and/or how often they are able to access them.
- Maximum length of ID varies across the WHO European Region, often from six to 18 months, and in rare cases there are no legal limits on the duration of detention.
- An individual assessment before detention to evaluate whether ID is necessary and proportionate and if the criteria for ID apply is not always regularly conducted by Member States.

3.1.1 Management and outsourcing in ID

Based on country reports from the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) and the Global Detention Project, management of ID can be categorized as government, government–local or privatized (81–114). ID facilities that are solely managed or run by government are often managed by a range of actors, including police, border guards or non-uniformed civilian staff with varying educational backgrounds (115,116). Government–local management is an alliance between the government and local authorities and can, therefore, include provincial police or cantons. Privatized management involves private (profit-making) organizations, such as the ones providing security or hospitality services, or NGOs; however, the government remains responsible for ensuring that ID adheres to human right standards (9,117). The execution of governmental powers by the private sector has led to concern regarding the power and responsibility, and the implications for human dignity (9,49). Available country data on the overall management of ID facilities from the Global Detention Project database in October 2021 indicate that most facilities in the Region were managed by governments, with some government–local initiatives and only a handful of countries with privatized management (data on management of some ID facilities was not known).

As reported by the Global Detention Project (118), both government-led and privatized management of ID outsource services within ID facilities to private companies. This includes services for security, catering, interpreting, cleaning and maintenance, educating and training; many also outsource health-care services (118,119). Legal counselling is often delegated to NGOs or private companies (119). For migrants in ID this can impact their trust in the legal system, with the belief that lawyers may be ethically compromised if they are hired by the

authorities that are trying to deport them (120). Outsourcing has become a norm and continues to grow, particularly in middle- to high-income countries (9,119,121). Although evidence and information on provision of services in ID facilities in the Region are limited, there was a report of countries shifting their contracts between private companies as well as back to government authorities (119); however, the reasons for these changes were not usually disclosed. A study conducted by the United Nations Working Group on the Use of Mercenaries found that there was very little oversight from governments of such private companies providing management or services, and limited national regulations that would ensure accountability (122). Further reports raise concerns about how privatization of management and services in ID has led to an emphasis on cutting costs, which has led to poor-quality services, understaffing, reduced health-care services and poorly trained staff (89,119,121). Further, inquests into deaths at ID facilities managed by private organizations have highlighted mistreatment of migrants by staff, and inadequacy of the health-care services provided (119).

3.1.2 ID environments

International law and guidelines stipulate that ID conditions must be humane and dignified (1,12,35–37,123). Migrants should have the ability to speak on the telephone, use the Internet and receive visits from relatives, friends and non-profit-making organizations (1,12,123). The ability to access an outside space should also be afforded, alongside daily recreational activities provided by the ID facility (1,12,123). Further, all individuals should be able to practise their religion and should have access to basic necessities (beds, shower facilities, toiletries, personal clothing, etc.) (1,12,123). Healthy food should be available, and food should be culturally appropriate (1,12,123). Conditions in ID are hard to generalize, yet many monitoring bodies and reports indicate that facilities often do not meet all of these standards (27,116,124–129).

The environments within ID in the WHO European Region vary considerably between and even within Member States. Often, conditions within ID are described as prison like, and migrants feel as though they are being punished because of the environment in which they have to live (44,90,95,107,111,120,125,128–133). Similarities to prisons include the use of barbed wire or high-security fences, individuals being locked into their rooms at night, set hours when recreational activities can be accessed, body searches, being referred to by a number instead of by name and staff wearing uniforms or carrying weapons – although not all these measures (if any) are enacted in all ID facilities (47,84,89,96,107,115,116,120,130,131,133–136). The prison-like characteristics in ID can often infringe the rights of the migrants within them, yet migrants in ID do not always have many of the services, amenities and rights made available to people living in prisons (116,124,137). Buildings that had been used for other purposes, such as prisons or military establishments, have been converted into ID facilities (84,85,90,92,102,104,138). Although some facilities have been fully renovated, others have been left with prison-like features such as fenced complexes and high concrete walls. The division of living accommodation has also varied within and between countries. Some ID facilities have separate wings for women, families, vulnerable people and unaccompanied children (53,83–85,96,100,106,108,136); others have combined accommodation (139,140). Parallel to accommodation, availability of, as well as access to, sanitary facilities can be either separated or combined.

Prison establishments remain in use for long-term ID accommodation in several Member States (46,48,97,106,141,142). This modus operandi has been denounced by CPT and the Global Detention Project on grounds that migrants in ID are neither convicted of a crime nor suspected and should, therefore, not be accommodated alongside criminal prison populations (97,106,141,142).

A common complaint is a lack of adequate food in regard to nutritional value, amount and cultural acceptability, and the inflexibility of when food could be accessed (120,128,133,143–145). However, a survey conducted among migrants in Sweden indicated that they were satisfied with the food provided in ID (120), and in some cases migrants may be able to cook their own food (115,116). Hygiene conditions also varied in ID. Many reports highlighted that ID facilities with large inflows and outflows of migrants were often unhygienic, with dirty cells or rooms, limited bathrooms or washing facilities, lack of basic supplies and limited or no access to fresh air (90,96,98,100,103,120,127,128,146–151). There were also facilities identified with relatively better standards (Case study 1), which provide sufficient numbers of sanitary facilities and rooms that were clean and well equipped (81,82,84,88,102,106,132,150,152,153).

• • **Case study 1. Positive examples of non-carceral environments in ID** • • • • •

A study of harm reduction in ID by the Global Detention Project gave two examples of avoidance of prison-like conditions (non-carceral) for ID in the WHO European Region (116).

Sweden

Migrants in ID have access to communication technologies and receive mobile phones that they can use for the duration of their confinement (although they do not have cameras). In addition, migrants have access to computers with Internet access. The staff at the centre are unarmed, come from a variety of cultural backgrounds and speak multiple languages. The majority of migrants agreed that the atmosphere in the centre was generally pleasant.

Switzerland

The Frambois Centre is a dedicated ID facility; the design of the facility is meant to downplay any similarities to a prison. Staff are not uniformed, speak a variety of languages, come from many different ethnic backgrounds and have received intercultural training. Migrants in ID are free to move around the Centre during the day and have access to a large common room with tables, seats, board games and a ping-pong table. Migrants in ID can utilize a tiny outside patio (surrounded by a wall) in the common area throughout the day.

Safety concerns have been reported by migrants. An assessment of a few facilities across the United Kingdom found that only 37% of migrants in ID felt safe (154). This was corroborated by many other reports showing physical injuries reported in ID (155), migrants fearing staff and other migrants in ID (120), and concerns about the number of fights and riots that occur within ID (156).

The amenities that are available in ID are very country specific and cannot be generalized across the WHO European Region. In terms of outside communications, some facilities allow

easy access to the outside world, with approved visitors able to enter, NGOs and agencies able to visit and migrants in ID given access to phones and the Internet (27,115,116). What often fluctuates is how easily the above are available. While most facilities allow visitors (27), there are cases in which NGOs have been barred from accessing and/or monitoring ID (133). Some facilities allow migrants to keep their own cell phones (99,131), especially if not equipped with a camera (82,83,105,108), although most seem to have a policy of collecting phones and either providing access (limited or not) to a stationary phone or providing mobile phones without cameras (81–86,89–91,98,103,106,115,135,136,149,157–159). Access to the Internet is often limited, either in the duration of access allowed or which web pages or online services are available (53,83,85,106,115), although, again, there are instances where migrants in ID are allowed to keep their own laptops (131). In rare cases, migrants in ID have no access to phones and other sources of outside communication such as televisions (107).

Leisure and educational activities are not always offered in ID. Some ID facilities provide language classes, access to libraries, religious services and gyms or outside courtyards where migrants can exercise (34,115,120,156). Access to outdoor areas can be highly restricted, and the areas unwelcoming and ill-equipped (138). The amenities available often depend on the specific ID facility in question, the average length of stay and the regime used by the facility. The freedom in which migrants in ID can access different recreational areas is often limited because of a need to share facilities across wings (160), or sometimes it can be based on the strict regimes set up by the management of ID (156).

According to country reports from CPT and the Global Detention Project, ID facilities operate on either an open or a closed regime. These regimes differ between countries, and occasionally within countries (104). An open regime favours migrants in ID moving freely within the accommodation, provides them entry to communal facilities and their rooms and allows free association with other migrants during the daytime. Facilities conducting a closed regime often do not allow migrants access to their rooms during the day or lock migrants in their rooms or units for most of the day (104,107,129). Delegations have noticed differences within these regimes between male and female migrants. These instances differ, including more restricted access to the open air for female migrants (90) and provision of an open-door regime for male migrants only (138).

3.1.3 ID in numbers

The EU Return Directive provides guidance on establishing a six-month maximum period for ID (36). This is not widely adopted, as the length of maximum ID duration differs between legal jurisdictions within Member States. Whereas a maximum period of ID is established by law, subclauses can lead to exceptional measures and extension of ID. These mandates provide for protraction in cases where, for example, the migrant refuses cooperation or there are delays in receiving necessary documents from destination countries (53,82,84–91,93,94,97,100–104,108–113,132,139,140,142,148,149,152,157–159,161–171). Parallel to these, Member States have different ID categories (Case study 2), each with their own timeline of duration (53,86,91,101,161,166,171). Generally, the maximum length of ID can range from six to 18 months, but instances with no indication of a maximum limit for ID in law occur (49,172).

Case study 2. Examples of varying ID categories in Member States

Croatia

Preliminary detention. A non-citizen can be detained as a safeguard to ensure their presence during the determination process of a probable expulsion. Its intention is to expedite the conduct of removal proceedings if a non-citizen is convicted of a crime or is seen as a threat to national security (86).

Regular detention. A non-citizen can be detained if he or she has failed to leave the country within the term of a return decision or expulsion cannot occur promptly. It can be imposed when the individual's identity needs to be verified, there is reason to doubt the person is a child or a return decision has not provided a deadline for departure (86).

Germany

Custody to prepare deportation. Custody can be imposed when deportation is considered difficult or impossible without detaining the non-citizen or a decision on expulsion cannot be immediately reached (91).

Custody to secure deportation. A non-citizen may be detained based on the following reasons: required to leave due to unlawful entry; deemed to display a risk of absconding; or is issued a deportation order based on a threat to state security that is not immediately enforceable (91).

Detention to obtain participation. Detention can be imposed for medical and identification examination if non-citizens fail to clarify their identity (91).

Hungary

Alien policing detention. Detention can be imposed when a non-citizen exposes a risk of absconding or is obstructing expulsion; frequently violates the code of conduct of the location of compulsory confinement; is discharged from criminal imprisonment; or has failed to report to the authorities (166).

Detention prior to expulsion. Detention can be imposed when the identity or legal basis of residence in the country of a non-citizen is not determined (166).

The Netherlands

Border detention. Detention can be imposed when a non-citizen does not possess valid travel documents or a visa; is deemed to be a threat to national security; or has inadequate monetary means to stay in the country (53).

Territorial detention. Detention can be imposed when a non-citizen has received an order for expulsion based on a stay without permission; is awaiting a permit application; necessary documents for expulsion are (soon) to be available; or it would be in the public's best interest (53).

Spain

Detention to ensure expulsion. Detention can be imposed for various reasons: a non-citizen is deemed to pose a threat to public order; remains on Spanish territory without authorization; is involved in profit-making clandestine migration; is convicted of a criminal offence where the law dictates expulsion to substitute prison sentences that will exceed one year (up to six years) or a fine (148).

Most governments indicate that they detain when noncustodial measures are deemed insufficient; yet an evaluation found that it was uncommon for Member States to conduct an individual assessment before ID to evaluate whether it is necessary and proportionate or if the criteria for ID apply (129). When such criteria do apply, less coercive measures should be prioritized; however, this does not often happen in practice. ID is frequently applied as a first option before ATD are considered, if they are considered at all (129). States share common legal justifications for the ID of foreign nationals, including the following reasons: the foreign national does not disclose identity, violates a re-entry ban or fails to comply, hinders or avoids expulsion; there is an existing risk of absconding; or to maintain public order or protect national security (83,93,110,158,161–165). The last is described differently among countries, varying from no clear definitions (112) to exhaustive lists of criteria (91). The country reports from the CPT and the Global Detention Project have highlighted that the risk of absconding is a commonly used ground for governments to impose ID. It may be used whenever there is a direct display of risk or reasonable concern that an individual may abscond (8,83,89,91,95,112,113,158,161,163–167,169).

3.2 Health outcomes among migrants in ID

KEY POINTS

- Migrants rated quality of life in ID as low, and many rated their physical health as very poor.
- The main risk factor for the overall poor health of migrants was the ID environment itself.

Communicable diseases

- In certain contexts, migrants in ID may have relatively high prevalence of tuberculosis (TB) and HIV compared with host populations, although the prevalence is not substantially high when compared with more similar populations (such as country of origin or migrants in reception centres).
- Migrants are at high risk for infectious diseases in ID facilities that are overcrowded, unsanitary, promote long detention periods, have no (or limited) access to fresh air or provide poor nutrition.

Trauma and injuries

- The research on health outcomes related to NCDs in ID is quite limited and what exists focuses on trauma, previous torture and physical injuries.
- The number of injuries and traumatic events occurring while being detained in ID is of concern.

Mental health

- The mental health needs and challenges experienced by migrants in ID is the most widely studied health topic, and many researchers linked the environment in ID to the exacerbation of poor mental health experienced by migrants.
- The most commonly diagnosed mental health disorders were depression, anxiety and post-traumatic stress disorder (PTSD). Other mental health problems such as self-harm and attempted suicides were also found.

- Duration of ID is positively associated with poor mental health: the longer the duration of ID the poorer the mental health.
- Migrants in ID had higher prevalence scores and levels of mental health disorders compared with similar migrant populations living in community settings.
- Migrants in ID also had similar or higher rates of mental health disorders compared with people living in prisons.
- A multitude of stressors in ID were found to exacerbate the mental health of migrants, including uncertainty around the duration of ID, language barriers, limited support systems, mistreatment from staff, overcrowding, being separated from loved ones and the injustice of feeling like a criminal.

Women's health

- ID is damaging for the physical and mental health of women.
- Women in ID exhibited greater levels of depression than men.
- Pregnant and nursing migrants experienced delayed or missed health care and often complain about poor nutrition.

Child health

- ID negatively impacts the mental health of migrant children, seemingly at greater rates than experienced by adult migrants in ID.
- Common symptoms related to the ID experience were sleep disorders, poor appetite, and emotional and behavioural outbursts.
- The mental and development impacts of ID were found to continue after a child had been released.
- Children also experience poor physical health outcomes related to ID, including development delays, food regression, exacerbation of prior health conditions and the experience of traumatic events.

3.2.1 Overview

The evidence presented here is from studies and reports that were often not conducted at a national or regional level. Some of the country examples and studies may only show the situation in a few facilities – sometimes as few as one or two – and so should not be generalized as representing the situation across all ID facilities in that country, much less ID overall in the WHO European Region. What is detailed here is the available information on the existing health and health challenges that migrants face in ID across the Region, which is relevant and important to address regardless of the number of facilities covered in any given study.

Two studies explored quality of life in ID and found that overall quality of life was low and that the dissatisfaction that migrants felt arose from varying aspects, such as lack of staff decency, safety, autonomy or dignity (28,154). One study found a positive association between the amount of support migrants in ID receive from staff and the four domains in the WHO quality of life construct: physical, psychological, social and environmental (28). Furthermore, general

health was associated with a migrant's ability to understand either the host country language or English along with the support received from ID staff (28), reflecting the importance of communication and proper staff training.

International agencies such as the IOM found that the general health status of migrants was comparable upon their arrival in ID to that of the local population (173); however, overall, substandard conditions in ID were found to be the main risk factor for poor health (42,125,174–176). A large EU study across 21 countries found that the duration of detention also impacted the overall physical health of migrants; 25% of those detained for a month rated their physical health as poor compared with 72% of those detained for between four and five months (125). A rating of poor health was more prevalent among children and young women 18–24 years of age (125). A comparison between detained and not detained female migrant sex workers found that those who were detained had a significantly higher average number of somatic symptoms (four, e.g. headaches, backaches, nausea, the shakes) compared with those living in the community (between two and three) (177). Similarly, a study of released migrants from ID found that 70% experienced somatic symptoms that considerably impacted their daily activities (176).

3.2.2 Communicable diseases

The current evidence on the risk and spread of communicable diseases in ID is mixed. Some studies found no immediate public health threats or outbreaks (such as lice, scabies or gastroenteritis) within ID (146,147), and that the level of communicable diseases among migrants was low (when looking at TB and hepatitis), although isolated outbreaks were reported of hepatitis A, influenza and measles (134). A random sample of migrants entering an ID facility at the Greek–Turkish border were tested for TB; 7.8% were positive, which was lower than expected in view of the percentages reported internationally for newly arriving migrants (146). All migrants testing positive were sent to hospital for further examinations, and four were diagnosed with active pulmonary TB and received treatment (146). Others in the sample were tested for HIV, hepatitis B and hepatitis C. Of those, only 0.2% were positive for HIV, 3.2% for hepatitis B and 0.8% for hepatitis C (146). In this case, the rate of hepatitis B was higher for migrants in ID than had been found in previous studies, but this may have been related to the prevalence rates in the country of origin for these migrant populations (146). Another study from the United Kingdom took a random sample of medical notes for migrants in ID and found that 3.0% were positive for TB, 1.0% for HIV and 2.0% for hepatitis B (numbers were based on self-reporting and so may be an underestimation) (178). These findings suggest a much higher rate of TB in the population studied (3.0%) compared with the results from screening of new arrivals at ports in the United Kingdom (0.24%) but similar figures to those from TB screening in a United Kingdom asylum reception centre (2.2%) (178). Almost half of the sample (48%) in ID reported not being screened for TB during their time there, suggesting further underestimation that is indicative of unmet health needs (178). The results reported above indicate that, while there might be a relatively high prevalence of TB and HIV among migrants in ID, the prevalence is not substantially higher than that seen in other populations with similar characteristics, such as country of origin and refugees and migrants accommodated in reception centres.

In situations where infectious disease protocols were not followed, sanitary conditions were poor and overcrowding was high, outbreaks such as primary varicella (chickenpox), gastroenteritis, scabies and TB have occurred (107,145,155,175,179–181). For example, an outbreak of chickenpox persisted over a seven-month period in an ID facility in Israel before the Ministry of Health was notified; in that time, 109 migrants contracted the virus (179). The delay in reporting is believed to have led to higher than necessary morbidity and spread of the virus (179). Poor sanitary conditions in some ID facilities have led to recurrent scabies outbreaks (175,180,181). Practices such as distributing a single razor for multiple users were observed in some ID facilities, posing a risk for the spread of bloodborne diseases (175,180). In another study, a relatively small chickenpox outbreak led to immunity testing for over 50% of the migrants in ID, of whom 8% were found to lack immunity to chickenpox (160). This was comparable to the figures for the local population although still of concern because of the risk of more severe disease in adults, especially with the potential for high contamination in settings like ID (160).

Respiratory, dermatological and digestive diseases pose a significant disease burden in ID (155,175,180,182). A study among male migrants in ID found that the most prevalent diagnoses were respiratory diseases (such as upper and lower respiratory infections and the common cold; 45.6%) (155). The next most prevalent diagnoses were digestive diseases (such as gastritis and constipation; 30.1%), while other communicable diseases were diagnosed in 16.0% (such as TB and hepatitis) (155). In this study, overcrowded living conditions within the facility were believed to have contributed to the occurrence and transmission of the diagnosed communicable diseases (155). This theme was found in many of the identified documents from the literature and in reports from intergovernmental organizations and NGOs, with concerns of overcrowding, unhygienic conditions, long detention periods, no access to fresh air and poor nutrition in ID placing migrants in ID at high risk for contracting communicable diseases (145–147,155,175,180,182–185). Box 1 uses the transmission of SARS-CoV-2 and the COVID-19 pandemic to illustrate this issue and Case study 3 provides country examples.

Box 1. The impact of the COVID-19 pandemic in ID

Risk factors and prevalence of SARS-CoV-2 infections in ID

The often crowded and unhygienic conditions found in ID have become of special concern during the COVID-19 pandemic because migrants in ID were seen to be at high risk, and quarantine was used as a precautionary measure (185–187). Some facilities failed to follow prevention recommendations, thus risking the spread of SARS-CoV-2 (107,181,188,189).

Reported outbreaks of SARS-CoV-2 infections in ID were found in only a few cases (107,190). In one ID facility, crowded conditions and a lack of quarantine measures facilitated the spread of the virus (107).

Increased restrictions in ID related to COVID-19

Some ID facilities were unable to implement physical distancing recommendations because of overcrowding and, therefore, management used isolation rooms to quarantine migrants who had recently arrived as well as those with suspected COVID-19 (191). According to a Global Detention Project report, newly arrived migrants were locked in their rooms during a 10-day quarantine period and only allowed outside for 1.5 hours during the day (191). The centre's supervisory board reported that these measures were "disproportionate" and the practice was "questionable". The board recommended that the centre reconsider its COVID-19 policies and consider the use of testing to limit the amount of time that migrants in ID were kept isolated from others (191). In another reported case, migrants in ID were not fully informed about their duration in ID as they had to wait for two COVID-19 tests to come back. This resulted in migrants being detained for over one month, all in relation to the public health measures enacted (174).

Case study 3. Positive examples of country provisions in ID related to COVID-19

Azerbaijan

The Global Detention Project (109) reported:

- placement of migrants in ID was halted on 24 March 2020;
- vulnerability assessments were conducted to identify the group most at risk of contracting SARS-CoV-2 infections;
- continuous medical examinations were provided to migrants already in ID; and
- sanitary supplies were distributed to all migrants in ID.

Belgium

The country limited the capacity of ID facilities and freed around half of the migrant population in detention to reduce the chances of a COVID-19 outbreak (192). Vulnerable groups and people who were supposed to be returned under the Dublin Agreement were among these migrants. Those who have been released, however, have received little to no help.

France

In one immigration centre (193):

- over 100 migrants were released from ID to enable physical distancing;
- evaluations were conducted to find any migrants in ID who were at risk for severe complications from COVID-19 and they were released on medical advice;
- staff and migrants in ID were recommended to wear surgical masks; and
- migrants in ID that tested positive for COVID-19 were transferred to specific COVID centres.

Ireland

The Country Report for Ireland in 2020 (194) reported:

- temporary release of low-risk migrants in ID, which reduced the population at facilities and helped to support physical distancing measures;
- leaflets and brochures were constantly distributed to all migrants and staff containing updated information on the pandemic and its risks, precautions and applied measures; and
- screening was provided for all those suspected of having SARS-CoV-2 infection, isolation of those with confirmed infection and testing available if required.

Russian Federation

Since 15 March 2020, by the Decree of the President of the Russian Federation, the country has suspended ID and deportation of immigrants because of the global COVID-19 situation; however, such practices have still been reported in several regions (188,195).

Turkey

The United Nations Network on Migration (78) reported that:

- facilities were regularly disinfected, and it was mandatory for gloves and masks to be worn by all staff;
- hygiene kits and personal protective equipment were distributed to residents;
- common areas were rearranged to make physical distancing possible; and
- pre-admission health screening and regular follow-up by physicians were conducted.

United Kingdom

The Home Office discharged almost 1000 migrants from ID in response to the spread of SARS-CoV-2, reducing the number in ID to the lowest it had been in 10 years (192,196). Additionally, the United Kingdom decided not to detain migrants from 49 countries where deportation was impossible because of travel restrictions.

3.2.3 Trauma and injuries

There is limited research and few data on NCDs in ID; the available research focuses more on trauma, victims of torture and injuries (29,34,134,155,197). One small survey found that 53% of migrants in ID developed new physical health problems while detained (for example, heart conditions, injuries or kidney damage) (176). Health professionals interviewed in ID facilities across Hungary, Poland and Slovakia noted that there were few NCDs, including physical injuries (134). In contrast, a review of medical records between 2013 and 2015 in a Greek ID facility found a concerning trend related to the number of injuries that were treated at the health centre, as almost 20% of those treated were linked to injury, poisoning or other external causes of harm (155). According to this study, this depicted potential safety concerns within the ID, noting that, even with the constant police presence, tensions and injuries were high (155). Some ID facilities also showed an increased risk for incidence of both sexual and physical assault (172,174,175). Migrants in vulnerable situations may have particular issues when in ID (Box 2).

Box 2.**Migrants in vulnerable situations in ID**

Some laws or policies stipulate who should be exempt from ID, such as those with vulnerability linked to health conditions (for example, pregnancy, chronic diseases or mental health concerns) and those who have been tortured or have experienced previous trauma (27,49,198). However, in other cases the accommodation of individuals with health issues is advised to be in ID facilities that are adequately equipped for their care (109,158,165,199).

An identification mechanism (or vulnerability screening) for individuals with disabilities, history of torture, suicide attempts or other vulnerabilities is important (55,93,99,112,198), yet is often missed in ID (55,96,132,138,139,149,200).

Although ID creates and/or exacerbates mental ill health, those with a mental health diagnosis or documented victims of torture were still found to be detained, regardless of their mental health status and the harm that continued detention could do (29,31,42,44,49,190,201,202). This has also been found with those with severe physical ill health and pregnant women (49,190,201,203). In one instance, these migrants continued to be detained even after concerns were reported to authorities (29). Even where safeguards exist to prevent migrants in vulnerable situations from being detained, ID was still utilized and prolonged (42) and, in some cases, has been indicated to have led to potentially unnecessary deaths (201). In other cases where screenings procedures are in place, individuals who are screened as vulnerable may still be detained because of the migration control measures (49,55).

A review of forensic examinations for migrants in ID found that the Istanbul Protocol was not followed as interpreters were not available, no history of previous torture or trauma was recorded and no psychological examinations were conducted (197). This may have led to victims of torture being detained even though they are explicitly considered a vulnerable group who should not be detained (197).

Doctors consulting with migrants in ID across the United Kingdom in 2006 noted that 36% of those consultations during a six-month period were with people with a history of torture and who showed physical signs that would support their verbal histories (29). Some migrants had been evaluated by clinicians in ID and had their cases reported; however, the authors were not aware of any measures taken to address the reported concerns (29).

3.2.4 Mental health

The prevalence of mental health disorders has been better studied in ID than other health outcomes for migrants. A recent meta-analysis found high prevalence of depression (73.5%), anxiety (64.7%), and PTSD (46.4%) among adults in ID, higher than earlier prevalence rates reported in the literature (30). Even though the meta-analysis included studies conducted in three different regions (Australia, Europe and the United States of America), prevalence rates were similar across all, with no association found between the region of the study and the prevalence estimates (30).

The environment within ID is found to cause a decline in the mental health of migrants (30,31,42,125,129,173,204–208), and strong evidence substantiates the mental health needs and concerns of migrants in ID (29,33,34,44,103,111,128,130,132,137,154,176,177,181,201–203,209–217). The evidence showed no mental health benefits related to administrative detention procedures (204), and a recent meta-analysis showed a trend towards increasing rates of psychiatric disorders in ID (30). A study evaluating quality of life domains in ID discovered that migrants scored the lowest on the psychological domain compared with the environmental, physical and social domains (28). The most common mental health problems among migrant in ID were depression, anxiety, a sense of powerlessness, varying levels of suicidal ideations, PTSD and personality disorders (29,31,130,176,204–207,209–215,217). Attempted suicides, self-harm and withdrawal symptoms were also found in the literature, although these were not as common (29,31,42,111,176,177,181,204,207,212,216). A range of other symptoms were also common among migrants and were found to be related to the ID setting, including sleep disorders, headaches, irritability and loss of appetite (31,130,204,206,207,216).

One evaluation found that 66% of migrants entered ID with at least one pre-existing mental or physical health condition that required ongoing treatment (176). For those who entered with a pre-existing condition, almost all experienced a deterioration of their mental health conditions while detained (176). For those who entered ID without any mental or emotional health problems, the majority ended up with mental health complications during ID (93%) (176).

Only one study in the review found that the duration of ID was not associated with depression, anxiety or PTSD among migrants in ID, in contrast to previous studies conducted outside the WHO European Region (34). This difference may be because the detention policies and length of ID in that context differed greatly from the other contexts previously studied as individuals can be detained for greater periods of time (34). However, the study did find that migrants in ID experiencing interpersonal trauma and detained for longer than a month reported more depression and anxiety than those detained for less than a month (34). Similarly, the evidence indicates that migrants experience worsening mental health effects as duration of detention increases (125), even becoming apathetic (207). During this period of demotivation, a variety of psychological symptoms appeared relating to post-traumatic stress (207). Another study found that those who were detained longer and had health problems experienced more distress and were less satisfied with the services received in ID (such as health care, safety, staff decency, communication and staff support) (154).

A retrospective chart review by Doctors of the World on their consultations with irregular migrants detained in Portugal between 2014 and 2016 found that 29% were diagnosed with a mental health disorder (204). In this case, female irregular migrants were found to be more likely to develop a psychiatric disorder in ID compared with men, even when the majority of the sample were men (84%) (204). Similarly, another study found that women reported higher levels of depression than men in ID (154). The same study found that migrants who had applied for asylum twice reported higher levels of depression than other migrants in ID (154).

The prevalence and severity of poor mental health is greater among migrants in ID compared with similar migrant populations living in community settings (34,177). Asylum seekers in ID reported more depression, anxiety and avoidance (related to PTSD) than asylum seekers

living in community settings (34). Female migrant sex workers who were detained reported high rates of depression (79%), significantly higher than a similar sample of female migrant sex workers living in the community (33%) (177). Rates of PTSD (17%) and suicidal ideations (47%) among detained female sex workers were, however, similar to those in migrant sex workers in the community (177). Suicide rates for asylum seekers in ID were much higher than the average found in the local population (112 and 9 per 100 000, respectively) (137). The researchers cautioned the use of these findings because of the small numbers of migrants in ID in comparison to the broader community but advocated for the need to better understand factors that are associated with high suicide rates within ID (137). Box 3 considers the differences between prisons and ID with regard to mental health issues.

Box 3.

Mental health of migrants in ID compared with people living in prisons

Migrants often liken ID to prison, stating that conditions are sometimes worse due to the uncertainty they experience (120). One study concluded that, compared with ID, prisons often have a more focused approach on rehabilitation intended to support personal development and social cohesion (204). Comparisons between migrants in ID and people living in prisons have found that migrants have similar or higher prevalence rates for mental health disorders as people living in prisons (30,33,137,209). Two studies found that over 70.0% of migrants in ID were diagnosed with a single mental health disorder (33,209). The study in Switzerland found 55.4% were diagnosed with more than one disorder (209), and the study in the United Kingdom found 16.0% with five or more disorders (33). These rates were high compared with the rates normally seen among people living in prisons in Switzerland (33) and comparable to the rates for people living in prisons in the United Kingdom (209). A meta-analysis found that migrants in ID had a higher prevalence of psychiatric disorders (anxiety, depression and PTSD) compared with people living in prisons (depression and PTSD) (30). Self-harm rates for migrants in ID were estimated to be 12.8% (potentially underreporting as only those in need of medical treatment were included), also higher than the rates found in people living in prisons in that country (137). Data between 1997 and 2005 show that as the number of migrants in ID increased, so did the suicide rate, potentially related to the impact of overcrowding; this reflected similar trends found in prisons (137).

A multitude of stressors has been identified that may impact the mental health and well-being of migrants within ID. Factors that aggravate feelings of depression and anxiety in ID were related to the uncertainty around the duration of and reasons for ID, being transferred suddenly between facilities (205), and the confusion relating to the legal procedures surrounding their migration cases (42,120,128,218). Furthermore, language barriers and poor communication contribute to feelings of powerlessness and isolation (31,120,137,154,205) and undermine the mental health care available to migrants in ID (212). The uncertainty associated with ID contributes to insomnia (206,210), which, in turn, increases anxiety and depression (207,211,213,218). Absence of proper support systems in ID has been shown to lead to high levels of stress and an inability to cope with that stress (111,120,218). One study found that the level of support

migrants received from ID staff was positively associated with their experienced psychological quality of life (28). Similarly, another study found a negative association between depression and the ratings migrants in ID gave on staff decency, communication and autonomy in detention, health care and staff support, with those migrants reporting higher depression giving lower ratings for all these factors (154).

Fear was related to mistreatment from ID staff, as migrants often felt that they could not report it, as well as to safety threats from other migrants in ID (120,211). For some migrants, even hearing about situations of sexual misconduct by staff towards other migrants in ID caused feelings of powerlessness and fear (219). The overcrowding in ID also increased the risk for psychosocial distress, including retraumatization and aggravation of mental health symptoms related to prior traumatic events (42,147,176). Other psychosocial stressors were migrants feeling that their health-care needs could not be met while in ID (205,210), substandard living conditions (120), isolation (87,120,154,211,218), lack of activities (128,153), separation from family members (especially parents separated from their children) (42,208,210) and the feeling of injustice or of being treated like a criminal (31,111,215,219).

One study found that 95% of migrants in ID reported at least one unmet need while detained that impacted their mental health (209). Unmet needs included the inability to have intimate relationships (77%), no support for psychological distress (73%) as well as lack of daytime activities (46%) and no support for physical health needs (41%) (209).

3.2.5 Women's health

There is limited evidence on the health of women in ID in the WHO European Region; this may be related to the lower proportion of female migrants in ID (13). While actual numbers for the number of women compared with men in ID in the Region are hard to obtain due to lack of disaggregate data (25), a global study on the detention of children found disaggregated gender data for 15% of countries, where 33% of the children were girls (13). In the United Kingdom, data disaggregated by gender are reported annually; in 2018, 15% of adults in ID were women whereas in 2020 only 7% were women (220). Furthermore, researchers emphasized the vulnerability and ethical concerns with conducting studies with female migrants in ID, as research may exacerbate their vulnerability (218). What evidence exists suggests that detaining women is damaging for both their physical and their mental health (121,125,128,143,144,154,172,203,214).

Detained women reported higher levels of depression than detained men (154), and women aged 18–24 years reported worse physical health impacts than other populations in ID (125). Pregnant women reported symptoms of depression, loneliness, insecurity and stress related to ID (214). Midwives reported that this population seemed to be exhibiting greater levels of mental illness than the general population of pregnant women that they encountered in community practice (143). A qualitative study indicated that the distress experienced by women was attributed to the lack of privacy and medical confidentiality. The women felt violated as staff (both male and female) would enter their rooms and bathrooms without warning to perform random checks (144). Staff commonly attended medical appointments both within ID and in secondary

facilities, and women felt especially exposed when “delicate” procedures were performed (for example vaginal examinations, or consultations related to previous genital mutilation) (144).

Studies on pregnant women in ID found that antenatal care guidelines were often not followed (143,144,203) and that the main objective of ID (to deport the women) was rarely achieved in the end, as most women were later released into the community to await results of their migration cases (143). In relation to physical health, a major issue pregnant women experienced was difficulty in the continuity of their maternity care (143,144,214). Appointments scheduled outside of ID were missed if there was no member of staff available to escort them, leading to untimely care, and there were not enough midwives available in ID so women often met a new midwife each time (143,144). Women mentioned that the staff in ID did not take their health concerns seriously and that they were not believed, often resulting in delayed care or never receiving any medical attention (143,144). Women experiencing high-risk pregnancies or miscarriages did not receive psychological support, and medical care was often delayed (203). Examples of such suboptimal care led to obstetric emergencies (143). Another major concern was the lack of adequate nutrition. Meal times were found to be too rigid, and the food available neither nutritious nor culturally appropriate. Women often felt hungry as they were not able to keep food in their rooms (144). This is concerning, as inadequate nutrition can affect both the mother and the growing baby. Finally, antimalarial treatments were also not provided to pregnant mothers who were supposed to be deported back to their home countries in places endemic for malaria (143). Other women who were prescribed antimalarial drugs sometimes had medications that were contraindicated for pregnancy or other chronic health conditions (143).

3.2.6 Child health

Similar to research on women's health, the research available on children in ID is sparse, probably for the same reasons (218). Many countries detain children; globally at least 77 countries are known to allow the detention of children for migration-related reasons (221). Globally, it is estimated that at least 330 000 children may be detained in ID, although this is assumed to be an underestimate because of the difficulty in collecting data and the lack of disaggregated data (13). Within the WHO European Region, at least 40 countries detain children for immigration purposes (13). However, the international legal position is that children should never be detained for reasons of their immigration status or that of their parent(s) (13,38–40,222), as it can threaten their physical, mental, emotional and developmental health (13,221,223).

The rules pertaining to the use of ID for children vary across the Region. Some Member States have laws that explicitly prohibit ID for children under a certain age (usually those younger than 14–15 years) or who are unaccompanied (46,88,89,95,101,158,164,167,224), while other countries do not detain children for immigration matters on principle (87,91,149,221,225). Despite international law, many countries detain children under some circumstances, such as when the family is detained or children are over a certain age (8,13,48,49,56,86,98,99,101,104,109,112,139,148,161,165,166,169,221,226). Improper age-determination examinations or delayed processes may lead to the arbitrary detainment of children (97,101,110,113,148,181,227,228).

The few studies and reports that examined health outcomes for children in ID predominately focused on mental health. In all cases, children were found to be negatively impacted by their stay in ID (13,30,32,44,89,130,203,208,229), with deterioration in mental health being more severe in children than in adults (125). Children in ID reported feelings of injustice and were distrustful of authorities (230). The provisions and restrictions in ID, such as surveillance or children being restricted to their rooms with no activities, impact the mental and developmental health of children (44,89,104,203). In one study, children who had not been diagnosed with a mental health disorder prior to ID reported symptoms of depression and anxiety, reflecting the impact of ID (130). The most common symptoms reported by children in ID were sleep problems, poor appetite, emotional symptoms and behavioural outbursts (89,130,208,229), and more severe mental health concerns such as attempted suicide and self-harming (13,208). The psychological effects discovered in one study were found to remain long after the children were released from ID (Case study 4) (208).

• • **Case study 4. The health of unaccompanied children in ID in the United Kingdom** • •

A legal case was brought by 35 unaccompanied children who were all detained during their migration cases but were later released when they were recognized as children. Medicolegal cases were completed for all of them by clinicians who based their findings on the analysis of prior records and their mental health assessments. The clinicians reported that ID caused 29% of the children to develop PTSD; caused exacerbation of PTSD symptoms in 51%, development of major depressive disorder in 23% and exacerbated major depressive disorder for 40% (32).

Of the 35, only four were found not to have any exacerbation of pre-existing mental health conditions or diagnosis of a new condition relating to ID. An association was found between the length of ID and the number of distressing experiences that were reported. Those children who were detained longest reported the highest number of distressing ID-related experiences (for example, body searches, witnessing fights, being handcuffed, being threatened or solitary confinement).

Children in ID also experience poor physical health (130,203,208), with the physical health impacts found to be worse for children than for adults (125). Newborns delivered in ID may not always receive necessary treatment, such as vitamin K, and may not receive initial immunizations (214). Many of the children referred for paediatric assessments complained of a recent onset of somatic symptoms, while others complained of exacerbation of prior physical conditions (130,208); and there were also signs of developmental delays (208). The lack of flexibility in meal times and an inability to provide nutritious and culturally appropriate food for children resulted in missed meals or food regression for children (89,130,208), and poor eating habits were found to affect children's physical health (229). Delayed and missed medical treatment was also reported: children not being referred, secondary health-care appointments missed and medical needs sometimes not recognized (130,208). Children in ID were witnesses to traumatic events such as violence and racist remarks that affected them long after they were released (208).

3.3 Health services in ID

Management of health care

- Management of health services varies; it may be operated by the government, private companies or through NGO services. In some cases it may be a shared responsibility between different entities.

Health-care provision

- Emergency care and essential medical care are provided in almost all ID facilities; what is lacking is specialized care and/or access to secondary and tertiary health-care services. This often depends on the referral systems and contracts in place between local health-care services and ID facilities.
- Medical screening is often provided upon entry to ID (although mainly for communicable diseases); it is, however, rarely systematically incorporated or is not comprehensive, as very few facilities include psychological components in screening.
- The range of health-care professionals working in ID facilities is not consistent and often depends on the size and capacity of the specific facility. Most often, nurses are the main health-care providers, with doctors available during specific hours or on call. The largest gap is the staffing of psychological health-care providers.
- Interpreters or cultural mediators are rarely employed, creating language barriers that can impact the quality of health care available and received.

Legal stipulations for health-care access

- Countries have obligations set by human rights legal frameworks to protect the health and well-being of all individuals within their jurisdiction.
- National laws on health-care rights often dictate what health-care services are available for migrants to access while in ID. Sometimes these laws may be ambiguous on what health-care services are essential; in other situations no such laws exist. In still other situations, laws only dictate the health-care rights of any detained individual, making no distinction between the health-care needs of people living in prisons, juvenile homes or ID.
- Most often health-care services are free of charge as stipulated by law, although in a few countries migrants must pay for specific health-care services.
- Laws may also dictate the type of health-care services provided in ID, level of staffing and the incorporation of relevant NGO providers.

Challenges in accessing and utilizing health care

- Mistrust of ID staff, health-care providers and western medicine may prevent use of services that are available.
- Communication barriers and cultural barriers are often identified.
- Availability of health-care providers varies widely among facilities and countries.
- Often medical records are poorly maintained or do not exist and they lack integration.
- ID staff may act as gatekeepers for accessing health-care providers and/or health-care services.

3.3.1 Management of health care

Health services in ID are delivered in some EU countries by the government (119,231); some EU countries have a mix of responsibilities between government and NGOs (112,119) while in others,

health service provisions are mainly dependent on NGOs and private health-care companies (49,103,106,116,119,180,217). Where NGOs are mostly reliant on EU funds and volunteering staff, there is evidence that health services are subjected to inconsistencies and have limited sustainability (180). The outsourcing of health-care services to private companies was considered a cost-efficient solution in some cases (103), while in others the quality of health care provided was a concern (106).

In some cases, differences occur within the same country. For example, in the United Kingdom, the National Health Service delegates the management of health services to other private entities in England (119,232,233), while in Northern Ireland and Scotland the responsibility of assigning care lies with the immigration authority (119,232,233). In some instances, where private organizations are responsible for providing health-care services in the facilities, some regulations on the recruitment process are applied. This is the case in Belgium, where all health-care providers (except for doctors) are members of the Office for Foreigners, which is controlled by the internal Federal Public Service (119), enabling better governmental oversight and supervision of the health-care provision and quality of hired providers.

3.3.2 Health-care provision

The provision of health care is often according to the laws that stipulate the rights available to migrants. Provision is also related to how staff in ID interpret the laws. As a result, health care offered in ID ranges from emergency care only, whether at the facility or by referral to nearby hospitals (90,91,96,98,103,104,107,108,111,112,139,142,148,150,159, 162,190,200,216,234–236), to provision of standard health care at the same level as for the general community (27,86,88,89,102,105,106,109,113,132,149,152,157,158,163,169,178,202,225,237–239). In the former, it is not clearly stated as to who will bear health-care costs since migrants in ID are occasionally expected to pay health-care costs and/or for medications (83,96,115). This may not, however, be very prevalent because in practice costs are often covered by the entities in charge of migration operations (115).

Medical screening is offered within many ID facilities. What varies is when they occur, who performs them and how comprehensive they are. Some countries perform screening directly upon admission (33,178); in others it may take place from 24 to 120 hours after arrival in ID (81,84,85,88,89,92,99,100,103,105,106,113,135,138,159,226,240–242), and in some cases screening is not systemically offered at all (82,90,94,96,98,102,104,107,115,132,136,139, 149,152,165,181,200). Initial medical screening often incorporates checks for infectious diseases, often through self-reports (such as for TB, HIV and hepatitis), health history and, less frequently, a mental health screening (85,99,107,131,146,178,181,225,242). Sometimes screening for transmissible diseases is not consistent for all migrants in ID (96,104,241). An audit of an ID facility's records found that 48% had never been screened for TB upon entry, even though all migrants were supposed to be screened for infectious diseases (178). Other audits found that many medical screenings were rudimentary, could not actually identify health conditions and needs (201), were not systematically incorporated (134) or if systematically required, were not observed (240). Additionally, screening of transferred migrants from other ID facilities and returnees from incomplete deportation procedures is sometimes overlooked (138). These screenings are as beneficial for ID staff as they are for migrants since they can provide evidence for any claims of excessive use of force by staff (138).

Mental health screening is only offered in a few countries (100,138,146). Such screening is considered a very necessary provision in relation to the detrimental effects ID has on the mental health of many migrants (130,134,148,198,205). These screenings are occasionally carried out by nurses trained in mental health (132), although from the records reviewed there does not seem to be any standardization of mental health screenings across the Region. Based on the mental health screening, some facilities offer psychological counselling and other supporting activities (95,96,243). However, in certain cases, the focus of the assessment is to assist administrative work in ID (such as completing necessary paperwork), giving less priority to providing migrants with psychological support (96,202,216,236); this is an example of where clinical independence is not respected and the duty of care is not ensured.

A comparison between the mental health screenings provided in prison and in ID found that those in ID were much shorter and less comprehensive, with some screenings in ID only consisting of four questions (137). Migrants in ID have remarked that they are not sure if a mental health screening was done when they arrived, as the first few days are often quite confusing and overwhelming (210). When screening was performed, migrants were often not informed about the aim; if health concerns were raised with staff, the migrants often found that there was no follow-up or support offered (210). It has been mentioned by agencies and researchers that mental health and vulnerability screenings should be revisited throughout the period of ID (for example, three months after admission), especially for those detained for longer periods (198,210,224). There are, however, positive examples of targeted health-care provision in ID facilities (Case study 5).

• • **Case study 5. Positive examples of targeted health-care provision in ID** • • • • •

• • **Austria, Vienna**

• • Migrants in ID on hunger strike are offered psychiatric care and transferred to the ID medical centre. Forceful feeding is not allowed and migrants can be released from ID for health reasons in extreme cases (239).

• • **Belgium**

• • On arrival, migrants go through a three-stage intake process. First, a social worker presents to migrants their legal case and the reasons for their confinement. Secondly, one of the educators informs migrants about the numerous services provided and the facility's policies. Lastly, medical screenings are performed by a nurse (115). Migrants in ID are also shown a short film that explains the facility's policies, the repatriation process and other pertinent information. Written information (typically leaflets) is provided to migrants to inform them about the rules and regulations that must be respected in ID, in a language that they are expected to understand.

• • **Croatia**

• • Migrants in ID are subjected to a general medical examination upon arrival. The examination must take place as soon as possible or within 24 hours if an irregular migrant is admitted to ID after normal working hours (153). The Croatian Red Cross previously provided a special phone line for irregular migrants to receive psychological counselling, and, in rare situations, a psychologist would visit migrants in ID; however the practice was halted owing to a lack of resources.

Health-care providers are incorporated within almost all ID facilities, although often less frequently at transit zones or locations where individuals are detained for 24 hours or less (they are often available on call). The type of health-care providers available and the hours they work within the facility fluctuate; for example, working hours for health-care providers range from full-time (27,81,84,85,90,92,93,100,102,103,105,108,111,131,132,135,149,157,159,165,169,239,242) to part-time attending only three weekdays (82,92,99,100,104,157,181,225), to only once a week (27,82,104,106,108,139,202) or overnight (89,100,105–107,216,241). More highly populated ID facilities with a large turnover of migrants may employ full-time health-care providers who are even available during weekends (27,88,99,100,102,104,107,132,216). Other facilities may only have weekly rounds available and on-call capabilities for emergencies (27,33,81,85,102,132,135,161,165,169). Large gaps were found in the availability of mental health professionals (27,115,134,216).

Some facilities receive support with the provision of health-care services from volunteering physicians and psychologists from various NGOs, such as the Doctors of the World, the Jesuit Refugee Service and the Red Cross (112). For example, Medical Justice, an NGO in the United Kingdom, provides medical services to migrants in ID and conducts studies and advocates for better conditions in ID (201). Across Europe, the Jesuit Refugee Service provides services in ID in the form of medical and legal aid, psychological services and monitoring the conditions in the facilities they work within (244). There are many similar organizations across Europe and within States that provide important aid to migrants in ID.

Interpreters or cultural mediators are rarely employed in ID facilities (95,96,102,103,105,115,134,137,149,165,189,203,207,216,245). Even when interpreters were available during health-care visits, it was found that fellow migrants and staff in ID were occasionally used instead (section 3.3.4 discusses the challenges in accessing health care in more detail) (88,90,91,96,103,115,138). In other cases, NGOs, interpreters and telephone interpretation services were available to provide translation (120,241).

While basic medical care is often offered in one way or another, specialized care is often lacking (130,134). Some ID facilities have referral systems in place and can transport migrants to local hospitals or health-care centres (84,99,106,113,115,202,203,239,242). Other facilities lack the necessary agreements or referral systems through which to provide migrants in ID with access to secondary health care (240). Health care for specialized and vulnerable groups is often absent, such as treatments targeted to support children and pregnant women (130,134,216).

Medical centres in ID are generally well equipped with emergency tools (such as defibrillators) and basic diagnostic tools, and are able to handle a variety of chronic diseases and meet basic health-care needs (84,85,88,99,100,104,106,131,157). Some are able to provide prescriptions for migrants with prior medical conditions (203,242). In some cases, medicines that would be targeted to the needs of migrants such as TB medication have not been included as essential medicines for ID (240). However, some centres were found to have deficient or scant equipment and lacked necessary medications for the most common health needs (86,96,98,99,105,107,139,190), and there have been cases where facilities were found to lack even the most basic health-care facilities (246).

3.3.3 Legal stipulations for health-care access

Countries have obligations set by human rights legal frameworks to protect the health and well-being of all their residents (15,62,63). EU directive 2008/115/EC also stipulates the health-care standards that should be afforded to migrants in ID; this includes the provision of emergency health care and treatment of essential illnesses (36). Other international frameworks such as the Nelson Mandela and Bangkok rules provide legal frameworks on the provision of health care in prisons, and these could be adapted to provide guidance on minimum requirements in ID (247,248).

In practice, not all countries have laws that stipulate the health-care access rights of migrants, especially those who are in ID (110,112,167), although this has evolved for many countries over the years by adapting laws or adding laws to specifically stipulate health-care access for migrants in ID (82,83,101,167,243,249–251). Even when laws are enacted, it is not always clear what level of access migrants in ID have (83,94,101,108,110,140,148,165,166,202,249,250,252), and health-care access may not even be equal between facilities within the same country because of this issue of interpretation (153,253). Some laws designate the rights specifically for migrants in ID as such (48,83,86,113,163,199,251), while others describe the health-care access available to anyone detained in the country (prisoners, juvenile offenders and those in ID) (254).

Commonly, national laws allow migrants access to primary health-care services (83,93–95,101,108,109,113,140,148,150,158,163,166,199,225,234,235,243,251,252). However, some laws only provide more restricted provisions such as medical screening upon arrival to ID (86,95,163,225,251) and emergency services (86,93,113,150,153,158,163,165,166,225,243). Others stipulate the provision of prescribed medications, laboratory tests and vaccinations (95,109,158,235). Referrals to regional or prison hospitals may also be stipulated (95,113,163,190,235,252); ambulance transport and access to secondary health care (158) may also be included. Finally, provisions are sometimes made for psychological and social support (243,252), although these are found less often. Provisions may also stipulate the access to healthy nutritious food, especially to promote optimum development for children and risk-free pregnancies (89,93,95,109,163,166,243). In some instances, the law gives the attending ID doctors the authority to decide on the level of health-care access needed for each specific person, although the decision must be approved by the managing director (190). For example, physicians can decide to refer patients to a specialized hospital or recommend the suspension of ID altogether (235).

Some laws highlight the importance of the presence of a health-care centre inside ID that is run by adequate and qualified health-care professionals (93,95,113,163,166). The provision of interpreters is sometimes regulated by law to ensure good communication and interaction between migrants and ID staff (read more on challenges with interpretation in sections 3.3.2 and 3.3.4) (95,113,148,225). Laws can also stipulate access to ID facilities for NGOs and national societies approved by the appropriate authorities (165).

3.3.4 Challenges in accessing and utilizing health care

Seeking health care in ID is complex in nature and is not as simple as whether or not health care is available but is also tied to factors such as trust, communication, cultural factors and staff and/or health-care provider availability (42,55,95,96,137,143,144,204,207,210,233,240,255,256). One study found that 73% of participants interviewed had requested health care during their stay in ID (such as a doctor visit, or referral to hospital) but never received it (176). Furthermore, 33% stated they had difficulties seeing a health-care provider in ID; 17% complained that they only received painkillers despite multiple health needs; and 10% said they were on prescription medications before being detained and struggled to access them throughout their time in ID (176).

Some migrants find that many of their health-care needs stem from being detained in general, which they see as unjust (255). Therefore, any health care or assistance they receive would need to target the cause of their suffering (ID itself) (255). Many are hesitant to seek help for physical or mental health symptoms because of the impact they suspect it might have on their asylum or legal cases (120,210,219,255). Other migrants did not utilize health care because they saw how others who requested help were considered to be taking unfair advantage of the system by staff and requests were ignored regardless (120,210,219,255). Furthermore, many saw that their requests for medical support to both health-care providers and ID staff, whether it be for mental or physical health concerns, went unheard or were not handled in a timely manner (42,82,83,103,120,143,144,181,210,216,255). This was especially seen in relation to mental health concerns, as migrants felt that the dispensing of medication alone was not truly supporting them and their needs (210). Some migrants in ID would refuse or pause their treatment because many did not trust western clinical medicine or the intentions of health-care providers in ID (204,210). Additionally, tense relations between migrants in ID and staff created an unwillingness in migrants to show any signs of weakness, or created a lack of trust in staff overall (120,255).

Communication barriers may be related to how rare it is for interpreters to be hired in ID (see section 3.3.2). This creates language barriers and influences the quality and completeness of the health care provided to migrants, who are often from diverse contexts and usually unable to speak the host country's language. For example, medication adherence was low when migrants could not understand the treatments they were given (210); others may not have fully understood the potential side-effects associated with treatment (29). Other migrants in ID were not sure how to adequately describe their symptoms due to communication barriers and different cultural perspectives (210,216). The large numbers entering and leaving some ID facilities may contribute to the unavailability of interpreters during health screenings and lead to poor record keeping and lack of continuity of care (137). Furthermore, the use of migrants and staff in ID as informal interpreters does not preserve the confidentiality of migrants (88,90).

Medical consultations provided in ID could sometimes be inadequate (29,176,201,210). This may be related to health-care staff availability and inherent challenges with staff providing care in ID (discussed further in section 3.4) (55,137). Other factors were related to the short

length of consultations, lack of interpreters, poor clinical protocols or lack of adherence to procedures (95,96,102,103,105,138,149,165,201,210,216,256). An inquest into deaths in ID in the United Kingdom found that ID often interrupted the continuity of mental health care for migrants, which was detrimental to their health (201). Migrants with suicidal thoughts may be transferred to a prison medical wing rather than a psychiatric hospital unit, which often aggravated symptoms as they felt that this was punitive, inadequate treatment (207). In some cases, there may be disagreement with clinical diagnoses; in particular, some staff may report migrants in ID who are exhibiting mental health symptoms yet once evaluated by a health-care professional are not diagnosed and do not receive treatment (210). In other instances, medical volunteers have stated that their concerns about the mental health of migrants have gone unheard, and the migrants are often not referred and, therefore, do not receive adequate support (144). In other cases, a lack of collective responsibility in ID was noted, which translates to recommendations not being properly implemented to ensure the health and safety of the accommodated migrants (42,201).

Medical records, which consist of routine and confidential documentation as well as the results of all screenings, examinations and prior medical history, are considered an essential method to enable continuity of care (91,100,131). Absence of medical records, a serious gap, was found in some ID facilities (91,100,104,105,130,131,134,139,240). In facilities where records were available, they were sometimes accessible by ID staff and migration authorities, in breach of migrants' right to medical confidentiality (82,83,142,242). The lack of systematic health data collection and reliable data is concerning as this results in unavailability of information on the health and health needs of migrants in ID; consequently, appropriate care cannot be provided because of lack of planning (240). Lack of medical records also means that continuity of care is breached, and provision of care may be delayed or missed when migrants are transferred from one ID facility to another (29,130,144). This is also of concern if a migrant is deported, as having medical records and having access to these records are essential if health monitoring is to continue (240,242). In addition to not collecting health data, not taking action on reported issues of concern is equally important (29,31,201).

General custodial staff in ID often act as gatekeepers to health care. As health-care staff are rarely present 24 hours a day seven days a week (see section 3.3.2), migrants must go to staff and request an appointment or indicate the need for emergency care. This has resulted in delayed care and medical complications (42,143,144,212,213). Guards or security staff play a role in the provision of health care and some emergency treatment (83,131,138,169). Occasionally guards and security staff are responsible for dispensing medications, thus invading the privacy of detained migrants (90,132,152). They may even oversee migrants' medical visits within the ID facility, which causes a breach in the confidentiality of these visits and limits the clinical independence of health-care staff (101,103,132,158,203,216, 225,242). In other instances, they are responsible for the decision to refer or not to refer a migrant in ID for medical support (82,138,139,162,165). Staff may not be adequately trained to recognize the signs of medical emergencies or genuine health concerns (49,144,210,213). In other cases, staff may be required to escort migrants to secondary appointments outside of the facility, often resulting in untimely or missed medical appointments (29,144,212,240).

Mental health providers, in particular, may not be as present in ID (compared with general health-care providers), or facilities may not have the appropriate number of specialized health-care providers hired to support the needs of migrants in ID (83,86,96,108,132,210,216). Due to the limited numbers of health-care providers, waiting times might be long, and some migrants felt that this was an intentional way to limit their ability to receive support (210). Some migrants perceived health-care providers as antagonistic, leading to the nondisclosure of medical problems, and noncompliance with medical advice provided (210).

3.4 Personnel working in ID

KEY POINTS

- Staff are often uniformed and some carry weapons, even if they are not often used, which might hinder developing a positive relationship with migrants in ID.
- Staff often perform multiple roles at one time (administrative, security and care tasks). This may undermine their ability to stay professional or to create meaningful bonds, and it may create a sense of powerlessness among the migrants.
- Staff may fear migrants (regarding physical harm or communicable diseases, for example), creating the perception of migrants as a collective “them” and fuelling tensions and mistrust.
- Health-care personnel are often not trained for the specific needs of migrants in ID, especially regarding mental health.
- Training to support and educate staff varies by facility and country; training is often very basic and very few facilities provide comprehensive training in cultural sensitivity, nonviolent communication and health-specific issues. When training is provided, it is often voluntary or offered infrequently.

3.4.1 Range of personnel in ID facilities

Most ID facilities across the WHO European Region employ uniformed security staff, including police and prison officers/staff, border guards and private security staff (89,99,100,103,106,107,136,161–163,216,241,257). In some facilities, security staff openly carry weapons such as batons, firearms, pepper spray containers, tear gas, truncheons and handcuffs (84,88,89,96,102,103,107,135,136). However, these devices do not seem to be used that often (88,102). The CPT reports argue that openly carrying such devices can hamper the establishment of a positive relationship between staff and migrants in detention (88,103). In some extreme cases, staff and migrants in detention have little to no interaction because the staff remain behind blacked-out glass doors (131). Some ID facilities ensured staff are hired from all genders (81,106,135,157), which was beneficial for their relationship with migrants in ID (157).

Staff categories can differ between countries and ID facilities. In many contexts, ID staff may take on a plethora of roles and responsibilities outside of simply providing protection and security services (83,131,138,169,258). This may result in staff being responsible for providing information on legal channels, dispensing medications or handling medical and social work referrals, alongside other administrative tasks (83,90,131,138,169,258). A few facilities used a more diverse set of staff categories to delineate roles and ensure that there is a clear division of labour (115). In such situations, there may be staff categories that focus on the security needs and the legal and social conditions in ID, such as administrative workers, immigration officers, chaplains, educational staff, nurses, gym instructors, maintenance workers and guards (Box 4) (88,100,115,162,259).

Box 4. Health-care providers available in ID

It is difficult to present comprehensive information on the availability of health-care providers in ID facilities across the Region. Within the country reports reviewed from CPT and the Global Detention Project, only 38 of the Member States in the Region made any mention on the availability of health-care providers within the ID facilities visited (53,54,81–88,90,91,93–96,98–100,102–104,106–109,111–113,131,132,135,136,138–140,142,148,149,152,158,159,161–163,167–169,171,172,190,194,236,241,260,261). Those health-care providers mentioned in the reports ranged in availability, for example from those present only on an on-call basis (82,90) to those scheduled as being part-time or full-time (107,161). Available providers depended on the specific ID facility visited and were not representative of all ID facilities within that Member State; in some cases, it is not possible to understand the extent to which different health-care providers are available based on the information provided. In other cases, the providers mentioned may be volunteers and not hired staff (112). From what evidence exists, the following health-care providers were mentioned as available (to varying extents) within ID facilities:

- nurses (including public health and mental health nurses)
- physicians
- psychologists
- psychiatrists
- dentists
- paramedics
- health-care assistants
- paediatricians
- midwives
- physician assistants
- drug rehabilitation staff
- pharmacy technicians.

3.4.2 Challenges faced by health-care providers

Health-care staff rarely receive specialized training to prepare them for the specific needs of migrants in ID (115,134). One example was found of health-care providers receiving specific training relating to intercultural communications and how to deal with aggressive individuals (115). In a few cases, health-care staff may receive training from a judicial viewpoint, imparting knowledge of how to work in a prison or criminal setting (111,115). This may influence the type of care offered to migrants in ID, who often are not violent and have not committed any crime. Monitoring bodies and NGOs have voiced their worries concerning the independence of health-care providers directly employed by the police or government and, consequently, the confidentiality of migrants in ID (116,180,241). Doctors face challenges working in ID, such as high workloads with minimal resources, and often work in isolation from other medical colleagues (233). Doctors must also balance multiple obligations, for example to their patients and to management, so-called dual loyalty (233,262). The purpose of ID can leave health-care professionals feeling conflicted as they are unable to meet their professional obligations of protecting and promoting health (233). Furthermore, health-care providers may not be properly supervised within ID (233), and the lack of training causes chronic gaps in appropriate care for migrants (for example, providers may be unaware of safeguarding provisions in place, signs of mental health distress or proper techniques for cardiopulmonary resuscitation (201)) and this places stress on the health-care professionals themselves (233). Providers have described how inadequate they felt with regard to handling severe mental health disorders as they were neither appropriately trained nor with the experience to support migrants in ID (210). Health-care providers could only provide emergency care in some instances (so no preventive or primary health-care services) because of the large numbers of migrants transitioning through on a weekly basis (90).

3.4.3 Challenges faced by staff in general

How staff perceive migrants in ID may influence the support that migrants are able to obtain and influence their health and well-being. Interviews with staff revealed that many are on guard and fearful of potential physical threats from migrants in ID (210,255,258,259). These fears may stem from the unknown, as there is often a degree of uncertainty surrounding migrants' identity, personality, history and trustworthiness, and whether they have an agenda or represent a threat (259). There are instances in which monitoring bodies have remarked on aggressive outbursts directed towards ID staff by migrants in ID (216), although this was not commonly found. Staff may acknowledge that ID is harmful and may result in the physical and mental health concerns of migrants in ID, yet this initial empathetic approach tends to shift over time to a more negative perception of migrants in ID as a whole (255). This shift to a negative attitude leads many ID staff to establish a notion of migrants in ID as a collective whole, which may create distance and a notion that they cannot be believed (181,210,255,259). This lack of belief in the authenticity of what migrants say has already been discussed in section 3.3.4 and may resulted in delayed health-care access and unmet medical needs (143,144,255). There is, of course, a balance to be observed, as when staff are more able to relate to migrants on a human and individual level they may receive requests for special treatment or be asked to

help in ways that they legally cannot (258). Overall, the presence of trustworthy health-care providers helps migrants in ID to feel supported, and thus they are more likely to comply with medical advice and treatment (210). Staff also recognized that a good relationship with migrants in ID meant that they could observe changes more aptly and so help to prevent the deterioration of health that is often found in ID (210).

Understaffing and competing roles were mentioned as barriers that stopped staff from creating meaningful bonds with migrants (210,263). This left some staff feeling that they were “definitely part of the problem” (263). The ability to help or support migrants in ID was further hampered by the increasing restrictions and policies put in place by States, leaving staff to feel constrained and conflicted concerning the impact that they were having in ID (263). This also reflected unclear role definitions, which left staff straddling both care provision and security/safety responsibilities within ID (258,263). Staff working in ID (in a variety of roles) may be left feeling powerless as they are unable to match the expectations of their professional roles (263). Further, staff may feel overburdened by the dual roles they must perform, and the limited time they have available to try to positively impact the lives of migrants within ID (258,263).

ID staff may receive a variety of training to support their work and keep themselves and migrants in ID safe. Such training often included the basics such as first aid and fire drills (115), although other evaluations found that staff were not always up to date on these basic courses (90,134,226). Some facilities offered more comprehensive training, which might include topics such as intercultural communications, infection prevention, cultural sensitivity, self-defence and nonviolent communication techniques (115,160,242). In some cases, specialized training seemed to occur through staff initiatives and was not systematically enforced (134). Overall, these courses were often not mandatory and were offered infrequently if they were available; consequently, new staff might be left untrained for long periods of time (115). As mentioned above, staff in ID facilities may have to take on multiple roles yet often do not receive any health-specific training to prepare them for such duties (Case studies 6 and 7) (134). Some members of staff were concerned about catching diseases from migrants but were not aware of the personal protective equipment available to them or the vaccines they could receive (134).

Case study 6. Examples of divided staff roles

Austria

There are two different categories of doctors who work in ID (239). One category consists of doctors who work with the police to determine if ID can be instated or continued. The other category exists only to provide health-care services to migrants in ID.

Belgium

In ID facilities in Belgium, a nurse performs medical screening, a social worker presents the legal case and reasons for ID to the migrants and an educator is responsible for the social and practical aspects of migrants' lives in ID (115). Other staff roles included security, management and professional interpreters (although fellow migrants are sometimes used for interpretation in medical instances) (115).

Case study 7. Example of staff training in Swedish ID facilities

The Swedish Migration Agency has worked during recent years to develop better training for its staff. The Agency has developed a new basic training package for staff employed at ID facilities covering aspects such as:

- ID management, how to maintain confidentiality, personal data and data protection regulations;
- how to provide professional service and treatment;
- administrative law;
- the role of a civil servant;
- human rights and migrants' right to assistance in ID;
- how to communicate with migrants in a clear and easy to understand language;
- how to organize meaningful activities;
- the collaboration between the Swedish prison and probation services, the border police and the ID section of the Agency;
- how to build trust between staff and migrants;
- the return process (voluntary return or forced return) as part of a legally secure process;
- conflict management, de-escalation methods and self-defence;
- basic education in food hygiene and hygiene in general;
- basic education on mental health concerns such as suicide;
- mental help first aid and emergency care of a person at risk of committing suicide;
- cardiopulmonary resuscitation and first aid response;
- children in migration, the child rights perspective and their needs and development;
- human trafficking; and
- acute stress management.

The training is a combination of online and face-to-face activities.

Other reforms included developing guidelines on how to treat migrants in ID, avoid different interpretations of laws and ensure similar treatment of migrants across different ID facilities in the country.

The Agency's guidance functions as a basis for various processes and activities across all Swedish ID facilities. Similar guidance was also developed for staff on health care in ID, including preventive measures for suicide prevention and against mental illness.

Digitalization of legal cases was also introduced to ensure that there is a legally valid decision on placing a migrant in ID and that migrants were not detained beyond the allowed time limits.

3.5 Measures to address health challenges within ID

KEY POINTS

- Providing opportunities for staff to constructively interact with migrants in ID can increase the psychological well-being of migrants.
- Psychological support groups can benefit migrants by providing them with coping mechanisms and knowledge to offset the mental health detriments ID can cause.
- The integration of holistic health services (medical screenings, psychologists, social workers and health-care providers) was found to increase the quality of health care in ID, and subsequently improved the physical environment.
- Resources have been produced to support a variety of systems in ID, including training modules for staff, monitoring mechanisms and tools, as well as screening tools to assess the individual vulnerability of migrants before and during detention (see the Recommended reading).
- Mathematical models may be useful for communicable disease outbreaks to support public health measures, assess risks (and risk factors) and utilize resources efficiently.

3.5.1 Synthesis of available evidence

Interventions within ID are few and, of those, even fewer are focused on health and well-being outcomes for migrants. A few collaborative projects have occurred since the late 2000s that have focused on providing better research into health conditions in ID in the WHO European Region; the effectiveness of psychological support groups; methods to decrease the spread of infectious diseases; and methods to improve training, screening and monitoring within these facilities. The studies are often not focused on specific diseases but on improving the ID environment, health services and health and well-being for migrants in ID. One study found that there was a positive association between the amount of support migrants received from facility staff and their physical and psychological health domains (28). Staff members who were able to spend time with migrants in ID in a constructive manner were better able to direct them to necessary services (258), as well as catch early signs of deteriorating mental health (210). Solidarity between migrants in ID is another method of coping that enables the spread of information (about rights and conditions in ID) and sharing of resources (such as cell phones) (128).

A two-year project was initiated in a series of ID facilities to determine the effectiveness of psychological support groups (215). The support groups consisted of 15 weekly sessions, with each session lasting around one hour and centred on cognitive behaviour principles using techniques such as group discussions, role play and experiential exercises. The project was created to provide migrants in ID with essential mental health education, cognitive coping strategies and a safe space in which to express themselves and build interpersonal skills. Psychologists were in charge of mediating the sessions with the help of cultural mediators. The mediators were essential not only for their translating skills but more importantly for their ability to bridge widely varying views of mental health and the cultural experiences of migrants. Groups consisted of 10–15 migrants, usually grouped by native languages.

The programme was well received by participants with regard to its helpfulness and utility (215). The sessions most appreciated were those about mental health problems and stigma, and those focused on positive thinking and how to appropriately express emotions. Participants described how, after the courses ended, they could better relate to others, communicate their emotional needs and were able to learn and use coping mechanisms to offset the impacts of ID. The group dynamic offered participants the opportunity to learn from one another and provided a forum for shared experiences. Many mentioned that their psychological symptoms such as insomnia, anxiety and lethargy lessened in both intensity and frequency after participating in the programme. The psychologists believe that the programme was able to successfully equip migrants in ID with the skills and strategies needed to manage factors that were causing them psychological stress. The programme also helped to decrease the stigma surrounding mental health support, and participating migrants were then more inclined to seek support and treatment. Overall, the programme was greatly beneficial; although the required staff resources may not be available in all ID facilities, the use of similar booklets could be adapted to teach migrants about mental health and coping strategies in ID.

Specialized pilot projects offering holistic health services also improved conditions for migrants in ID at the Greek–Turkish border (146,147). Not only did access to basic and specialized health care improve, as the health-care team included a medical doctor, nurse, psychologist, social workers and a wide range of cultural mediators, but the project also improved physical conditions within the facility (146). Before the project started, migrants did not have access to outdoor spaces, and cells were not regularly cleaned; once the project started daily cleaning was initiated, which allowed detained migrants to access the courtyard and receive both fresh air and exercise (146). A refrigerator was also provided to store medications and necessary vaccines, which had been lacking prior to the intervention (146). According to interviews with all stakeholders (migrants, staff and translators), the project offered better access to health care and offered a more personalized and holistic approach that was appreciated (147). Case study 8 outlines the use of multidisciplinary teams to support health and well-being for migrants in ID in Italy.

• • **Case study 8. Multidisciplinary teams to support the health and well-being of migrants in ID in Italy** • • • • •

A multidisciplinary team in Catania, Italy, was formed through a joint collaboration between the local health authority and the Penelope Organization (an NGO), which works to give integrated help to migrants, notably in the field of ethno-psychiatry (a discipline that incorporates cultural dimensions) (264). This is an example of good practice in the provision of integrated health and social aid. The collaboration was made feasible by the establishment of a network and through ongoing communication with regional institutions and groups, including the local university.

Another intervention focused on harmonizing migration health along border routes for migrants (134). The three-year project incorporated different stakeholders (international and intergovernmental agencies, government officials and researchers) across three countries in the EU and started with a situational analysis to establish the needs for staff working in holding and ID facilities, as well as the health needs of migrants (134). From this, a set of training modules was developed to support border officials and health-care providers. Alongside that, guidelines were drafted to support a more standardized approach to health within ID (134,265). The developed tools still need further research and piloting to understand their true impact, and further standardization will hopefully be continued in order to create an adaptable yet everyday toolkit that could be used by border officials and ID facilities to promote better health for staff and migrants in ID alike (134).

Other training modules and guides are available to present key knowledge on ID and examples of best practices to equip individuals working in ID or involved in the monitoring of ID. The UNHCR has developed an online module (Fundamentals of Immigration Detention) and two self-study models (Immigration Detention Monitoring and Alternatives to Detention) to provide individuals with the knowledge to “assist in advocating for and implementing alternatives to detention” as well as for fundamental practices in connection to monitoring visits (266). Similarly, the IOM has developed tools to advocate for and advance the use of ATD and to support States in efforts to establish such programmes (267,268). Another report drafted by the British Medical Association provides guidance for doctors working in ID with the aim of providing support on the ethical challenges and dilemmas health-care professionals will encounter when trying to provide equivalence of care (233). The report addresses the various policies and current practices in ID in the United Kingdom that impact the health of migrants and provides guidance on the measures doctors can take to counteract them (233). Some of the guidance focuses on how to stay clinically independent, the use of segregation and restraints and how to better advocate for patients in ID (233). It also focuses on how policies could be revised in the United Kingdom to ensure the better health of migrants in ID (233).

There are a few different monitoring mechanisms and tools that have been developed over the years specifically targeting the needs of migrants in ID (12,262,269–272). One study used the monitoring tools developed by international agencies to develop a questionnaire that enables comparison of conditions in ID across countries (269). The questionnaire was individually filled out by all team members during the visits and then triangulated with the same questionnaire that had been filled out in advance by the immigration authorities in each of the countries, alongside the observations of the team members (115,269). The comparability of results obtained enabled countries to see how different ID facilities manage different aspects in ID (such as health-care provision, living conditions and training of staff) and allowed best practices to become visible (115,269). Two different monitoring guidelines provide checklists and details on the different aspects that should be evaluated when monitoring visits occur in ID (12,270), and a practical guide for NGOs on how to conduct monitoring visits in ID has also been created (Box 5) (272). Finally, there is a guide for health professionals on the importance of being part of these multidisciplinary monitoring teams, as well as providing guidance on what to look for and observe from a health-care perspective (262).

Box 5.**Aspects to cover during a monitoring visit**

The main aspects that would be beneficial to include in an evaluation when visiting an ID facility for the purpose of a formal monitoring visit are as follows (12,270):

- **procedures in ID:** such as the arrival procedures, access to legal aid, asylum procedures and complaint procedures;
- **treatment and disciplinary measures:** such as use of force, solitary confinement and allegations of improper treatment;
- **safeguards:** such as whether trauma assessments and medical assessments are performed upon arrival, and protocols for allegations of ill-treatment;
- **environmental or material conditions:** such as food/nutrition, hygiene conditions, clothing of migrants and accommodation;
- **daily regime and activities:** such as ability for migrants to contact the outside world, activities provided in ID and access to outdoor spaces;
- **health care:** such as health-care provision and staff numbers, access to initial health screening, and availability of specialized care, including access to essential medicines for vulnerable groups and people with mental health disorders;
- **personnel:** such as numbers and ratios, categories of staff, and training provided to staff; and
- **vulnerable populations:** such as whether screening for vulnerability occurs, the number of children detained, if ATD are considered, what policies are there for equality and the rights of various vulnerable groups.

The guides outlined above also provide details on the steps that should be taken after a monitoring visit is completed. This may include how to write up the review, the necessary documents to incorporate, debriefing of the team, how to disseminate reports and how to evaluate the monitoring strategy (12,270,272). Strategies were recommended on how to follow up and support the implementation of recommendations. One best practice was to share the monitoring report with immigration authorities before publishing it, allowing for feedback, increasing discourse and creating a greater possibility that recommendations would be implemented (272).

A vulnerability screening tool has also been created to assess the vulnerability of potential migrants in ID (198). Foremost, the tool can help immigration staff to determine if ID is the most appropriate placement based on the individual's vulnerability and needs (198). Screening can also help to identify the appropriate support services that an individual migrant may need to access in ID (198). Although this tool may be implemented before a decision about ID or ATD takes place, it can also be used as a screening tool throughout an individual's time in ID; this can be critical for ensuring the health and well-being of migrants and adapting appropriate support services accordingly (198). Vulnerability is assessed within a set of domains, which are not rigid but acknowledge that individuals may have multiple vulnerability factors alongside other external social and environmental factors (55,198). The questions are centred across four domains: (i) children; (ii) sex, gender, gender identity or sexual orientation; (iii) health concerns; and (iv) other protection needs (for example, for asylum seekers or stateless people). There is also a section to capture any factors that may be at play for that individual outwith these domains, such as

minorities at risk of xenophobic violence or individuals who speak a rare language (198). The tool also offers recommendations on how to proceed after the screening has been completed, what decisions need to be made, what referrals or support should be offered and how to communicate this with the migrant (198). This is the assessment phase and should be used to determine the needs of the individual based on their specific vulnerabilities (and contextual factors) and should result in a plan to address any resulting concerns highlighted during the screening (55). Some countries have already worked to adapt this tool to their national context and those ATD that they have available (273).

Innovative methods can be employed in ID when trying to manage the outbreak of communicable diseases such as chickenpox. In one case, the use of mathematical modelling was employed to guide an outbreak control team on what was the best strategy for containing a small outbreak of chickenpox (160). During this time outbreak protocols were followed, including the implementation of movement restrictions, isolating those with active infection and widespread immunity testing for varicella, as the outbreak occurred in a rather large ID facility (around 800 migrants) (160). Although immunity testing was found to be the best practice, it affected operations in the facility and it proved difficult for staff to keep up with the extra tasks (160). Therefore, mathematical modelling was initiated, and it was determined that halting immunity testing for the remaining 43% of migrants was the most feasible pathway forward, as the risk of contracting chickenpox was limited to one additional case (160). This method could be adapted to other large ID facilities, to better ensure public health protocols are followed, risks are accurately assessed, and resources are best utilized.

3.6 ATD

KEY POINTS

- There is no standard definition for ATD, or what constitutes ATD.
- ATD are often considered to be policies or programmes that provide migrants who otherwise would have been detained with the opportunity to instead reside within the community to complete migration procedures (sometimes with restrictions applied to ensure compliance).
- Many countries in the Region already have programmes that would count as ATD, and some require that these options are considered before ID is instated.
- There are a variety of ATD that are being supported across the Region.
- Ideal ATD are rights-based and case management-based approaches that focus on engagement rather than enforcement techniques.
- ATD also must apply safeguards and adhere to international human right standards to avoid any use of excessive restrictions on an individual's liberty or freedom of movement. The evidence indicates the following benefits of ATD:
 - improves compliance and engagement (with migration proceedings)
 - reduces the risk of absconding
 - supports fast and prompt case resolution
 - protects the health and well-being of migrants
 - more cost-effective than ID
 - improves the mental health of migrants
 - preserves the human rights of migrants.

3.6.1 Overview of ATD in the WHO European Region

There is no consensus on the definition for ATD or what the term legally stands for (244,274). However, the UNHCR considers ATD as any law, policy or practice that gives migrants more freedom to reside within the community, although this freedom might be restricted to certain conditions (1). The International Detention Coalition (IDC) adopts a similar definition: “any law, policy or practice by which persons are not detained for reasons relating to their migration status” (5). Broadly speaking, ATD encompass both enforcement- and engagement-based approaches (275). The former are those interventions that still impose some restrictions on freedom of movement yet do not constitute deprivation of liberty but are designed to control and keep track of migrants in less-coercive conditions than ID. The latter refers to methods that promote engagement with migrants as well as encouraging cooperation with the immigration system to work towards finding a temporary or a permanent migration outcome. Such engagement-based approaches tend to be in the community and provide case management based on trust. They prioritize the well-being of migrants, with no or minimal restrictions on the freedom of movement (273). Most NGOs and United Nations agencies advocate for and support the application of engagement-based approaches (273,275).

A variety of regional and global initiatives to increase the use of ATD are underway. The United Nations Network on Migration has a multistakeholder Working Group for Alternatives to Detention (78,276), which has produced ATD guidance documents and coorganized global peer-learning exchanges between States (277). The European ATD Network, facilitated by the IDC, is a group of NGOs in seven European countries implementing ATD pilots and evaluating their impact, often in partnership with national governments and local authorities (273). Furthermore, UNHCR's Global Strategy Beyond Detention was a five-year initiative (2014–2019) to support governments in ending the use of ID, which resulted in stronger collaborations between UNHCR, governments and civil society organizations, piloting of new ATD, legislative reforms and development of a variety of tools connected to ID (278).

EU law requires that Member States should not detain migrants without the consideration of alternative, noncustodial measures to ID and to preserve the mental and psychological health of those detained (36,37,279). The WGAD echoes this approach, recommending that States consider ATD first, ensuring that ID is used only as the last resort (38). These measures must adhere to the fundamental human rights of migrants (279). However, EU law does not limit the list of alternatives to specific interventions; rather it is up to each country to find the most suitable way to avoid ID within its territory (Box 6) (279). An evaluation of the recent initiatives to implement ATD in the EU found that migrants in vulnerable situations such as children and families have particularly benefited from the increase in ATD (280).

Box 6.**Examples of ATD available in the WHO European Region**

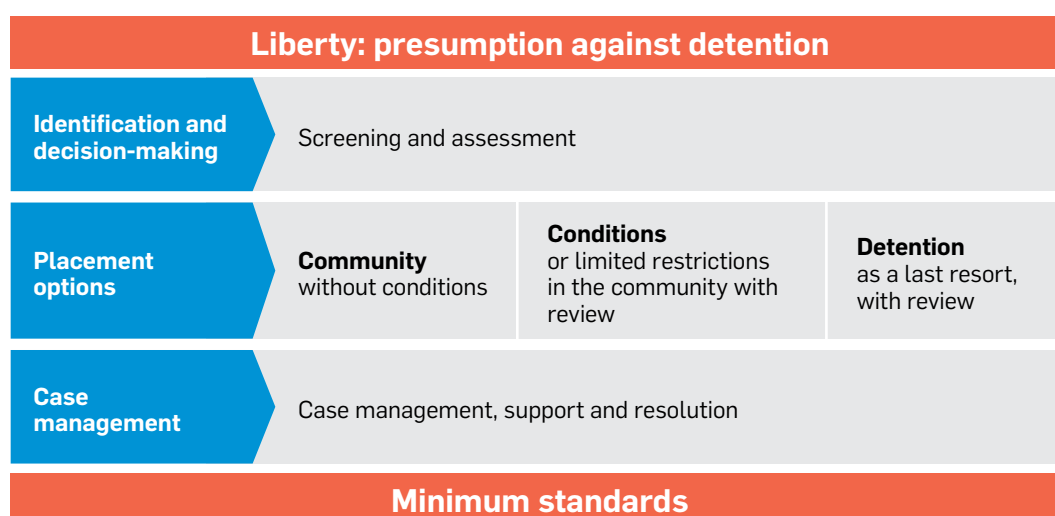
- **Reporting regimes.** Migrants are required to regularly report to immigration authorities or to the police (1–33), which might even require the surrender of a passport or other identification documents (8,86,87,91,101,108,140,158,162–166,238,250,278,281–289) for the duration of supervision, which would be reviewed after six months (83,226).
- **NGO supervision.** It is the responsibility of the supervisor provided by the NGO to whose care the migrant is released to check on the migrant in order to decrease the risk of absconding (87,225,287).
- **Restricted movements.** Use of electronic monitoring and home curfews (8,162,200,243,244,287,288).
- **Private accommodation.** This is paid for by the migrant, who must report if their address changes (89,95,161).
- **Open and semi-open centres.** Security guards in these centres have no authority to physically stop anyone from leaving (5,78,94,161,237,287).
- **Directed residence.** Dispersal and restrictions to a district where the residence of a migrant is restricted to a single home or area without the opportunity to relocate at will. The place of residence will be determined by the authorities instead of being the migrant's responsibility (8,53,78,86,87,91,94,97,101,110,111,140,162,163,165–167,169,202,216,244,250,252,282,287–289).
- **Open or return houses for families.** These are specifically designed for those with children. Curfews may still be in place but families are able to leave during the day, receive visitors and receive support from coaches, who provide logistical and social support (5,190,283,284).
- **Community placement.** This includes foster care, kinship care or independent living arrangements (79).
- **Monetary bond.** Provision of a bail bond with sureties (5,86,108,162,164,169,202,216,244,287,288) or deposit of a financial guarantee (8,87,89,91,95,140,165,234,252,282,284,285) is reported as a valid method, although most countries rarely apply it (169,252).
- **Surety or guarantor.** The surety provider or guarantor (243,244,279,284) can be a national of the country, long-term resident or a person with a residence permit (279).
- **Case management.** This is a thorough and systematic approach to service delivery that ensures assistance for migrants and asylum seekers, and a coordinated response to their health and well-being (5,79,244,283). It relies on social workers to recognize and respond to individuals' capacities, requirements and difficulties, including personal resources and vulnerabilities (5,273).

ATD are now being implemented in a number of countries in the WHO European Region, including Austria (282), Belgium (5,244,274,283), Bulgaria (273), Cyprus (273), Czechia (284), Germany (244), Greece (281), Hungary (284), Italy (281), Israel (284), Malta (284), Norway (78), Poland (273), Spain (186) and the United Kingdom (5,244). Some of these countries require authorities

to consider ATD before resolving to detain migrants based on an individual assessment (53,86,87,89,91,93,94,108,161–163,165,167,169,202,225,226,234,238,239,243,245,252,285). Some countries are not obliged to consider ATD first, and such options are only considered when the migrants have the financial means and accommodation to support their stay (95,200,286). There are also instances in which programmes labelled as ATD merely serve as a measure to impose additional restrictions on migrants. This is particularly applied to migrants who are not likely to be detained but where there is still some risk of absconding (113,140,181).

To make it easier for countries to implement engagement-based approaches for ATD, the IDC developed a framework to guide best practice. The community assessment and placement (CAP) model (Fig. 2) can be used to evaluate current laws, regulations and practice to identify the gaps, improve local ATD, facilitate conversations about ATD with officials and ensure that ID is only utilized as a last resort (5). There are two overarching principles and three key processes in this model (5). The first principle is the right to liberty of every individual, the prohibition of ID and the mandate to consider ATD before resorting to ID (5). The second is the minimum standards, referring to respect for fundamental rights and meeting an individual's basic needs, fair and timely case resolution, regular review of placement decisions and the availability of legal advice and interpretation (5). The processes consist of identification and decision-making, which recognizes the diversity of the migrant population and, crucially, focuses on the needs, vulnerabilities and capacities of the individual (5). According to individualized assessment, a choice is then made about the most appropriate placement options for the individual in question. The IDC identifies a number of placement options: (i) community without conditions; (ii) conditions or limited restrictions in the community (such as monitoring or supervision) with review; and (iii) ID as a last resort (5). Following the identification of the most appropriate placement option, the individual must have access to case management and support in order to work towards case resolution (5). Case management is promoted by the IDC as the ideal method to reach case resolution as it is built on an individual's strengths, identifies and addresses their individual needs and can contribute to a timely case resolution (5). The evidence presented in this section is adapted from this CAP model (5).

Fig. 2. Revised CAP model from IDC



Source: Samson et al., 2015 (5).

3.6.2 ATD for individuals with specific vulnerabilities

Children should never be detained for immigration purposes and alternatives should be offered (224). The use of family- and community-based alternatives are considered the best option for the needs of children but these again should only be used when necessary and for the shortest duration possible (Case study 9) (224). The IDC suggests the use of a five-step model, the Child CAP, based on CAP model. The option of detention as a last resort is not part of the Child CAP given the vulnerable situation of children. The Child CAP can serve as a guide for States to help to ensure that children are not detained (290). This model is specifically designed to ensure migrant children are placed appropriately and receive the necessary management and support. The following steps are recommended (290).

1. **Prevention** and the establishment of an agreement against the ID of children will involve the State's decision-makers.
2. **Assessment and referral** include the screening and placement of children. It takes place at the borders or within the country of first encounter. The screening process starts with a vulnerability screening. If the child is unaccompanied, he or she will be assigned a guardian. An allocated case worker will then conduct an initial intake assessment to place the child in an appropriate community setting.
3. **Management and processing** is a continuous process from meeting the child until a decision on the application for international protection has been made. It generates information that helps authorities to make informed and timely decisions and supports the child in accessing suitable community services. It proceeds to explore the best migration options, makes a best interest determination and assesses any protection needs.
4. **Reviewing and safeguarding** involves reviewing the decisions taken regarding the migrant child, the conditions in community placements and making sure that the child's rights and interests are safeguarded.
5. **Case resolution** is the final step and involves the conclusion of the child's migration case, whether to stay or leave the country. Family reunification is a priority. However, if not possible, integration into the local community should be supported.

For adults, ID should only ever be used as a last resort and, therefore, ATD should be used in the vast majority of cases. This is even more vital for migrants in vulnerable situations, including but not limited to people with diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC) (12,291,292). Therefore, ATD should be particularly pursued in these instances (291). ATD should involve community placement and support services uniquely designed to meet the needs of individuals with diverse SOGIESC. This can mean coordinating networks of support between the State, leaders and grassroots organizations working on diverse SOGIESC while a migrant's immigration status is being resolved (291,292).

Case study 9. ATD for migrants in vulnerable situations

Germany

The Government of the Federal State of Berlin has adopted a citywide policy that refugees and asylum seekers who are lesbian, gay, bisexual, transgender or intersex should be considered as applicants with special vulnerabilities and should be accommodated in special reception and accommodation centres designed to meet their specific needs (291). Specific training emphasizing the needs of this group of refugees and asylum seekers has been implemented for all personnel working in refugee reception centres as part of the policy's further development.

The Netherlands

Under Dutch legislation, the Nidos Foundation has the exclusive duty of arranging guardianship for all migrant children (293). The organization hires professional young people to take on guardianship. Guardians are responsible for representing the child in legal proceedings, supervising the child, advocating for the child's best interests and supporting the child's well-being and development. Guardians are also responsible for securing and overseeing the child's long-term care and living. In 2016 more than 2000 new guardianships were granted, increasing the total number of guardianships to 5678 by the end of 2016. Children were housed with foster families (33%), in small-scale residential facilities (28%) and in central initial reception centres (18%); the remaining 30% were housed and cared for in other ways.

3.6.3 Evidence on ATD in the WHO European Region

Despite the advantages of ATD, use is fairly limited in many Member States (83,86,89,93,95,97,108,113,148,158,166,170,200,235,239,261). In some instances, this is because of insufficient assessments to determine the feasibility of options (83,108) or because of assumed financial and social requirements (93,95,161). The use of ATD is often limited in transit countries where the risk of absconding is deemed to be high (86,89) or where States estimate that there might be a risk of not guaranteeing a complete deportation/expulsion process (239). This is despite the fact that ATD have been found to have high compliance and engagement rates, including in countries that are usually thought of in transit contexts (273).

Currently in the WHO European Region, there is a relative scarcity of evidence-informed studies analysing ongoing ATD to determine their effectiveness in Member States (244,273). There is also a lack of coordination in gathering evidence at the national level and advocacy at the regional level (244,273). The available evidence lacks synchronicity on a regional level, rendering advocating for ATD within the Region challenging (244,273). Additionally, the lack of coordination between national implementers, regional actors and evaluators presents a challenge for those working to gather evidence on the impact of ATD (244,273). There are efforts to improve this situation, including, for example, through the European ATD Network, which is producing coordinated evidence for ATD on a regional level (273).

While the aim of ATD is to improve adherence to the rights and well-being of migrants, ATD also must come with safeguards and adhere to international human rights standards to avoid causing excessive restrictions to individuals' liberty and/or freedom of movement. For example, some situations outside of the WHO European Region where measures that have been inappropriately labelled as ATD have still placed heavy restrictions on migrants' freedom of movement and rights. An Indonesian study evaluating the effect of measures considered as ATD on adults found that they imposed significant restrictions on migrants, who felt unsafe leaving their residences and were offered little freedom (294). Such detrimental effects are most likely to be felt when ATD programmes are based on enforcement and coercion, rather than the principle of engagement (273). By comparison, rights- and community-based ATD that rely on case management have been shown to lead to an increase in people's well-being and health outcomes (273). In addition, the concern with ATD may be the ambiguity of what counts as alternative, as some countries have enacted programmes that may still be stigmatizing and cause distress for migrants, such as the use of electronic bracelets (280), imposing more restrictions and even in certain cases deprivation of liberty. Situations where interventions effectively amount to deprivation of liberty should more accurately be labelled as alternative forms of detention, rather than ATD (280); hence the call for more research on evaluating ATD, and in particular the varying impact of different types and models of ATD. This is crucial for future scaling up, nationwide replacement and/or reducing the use of ID (125,154,295).

3.6.4 Evidence on the benefits of ATD in the WHO European Region

Importantly, as indicated above, many health challenges in ID are related to the fact that migrants are detained and the ID environment contributes to their poor health (28,145,173–175). These negative consequences will be mitigated or avoided when migrants are no longer detained (296). Studies have shown that migrants in the community have better health outcomes than those in ID (5,297). Hence, the need to study and apply new alternative methods to host these migrants are necessary and will have positive effects for the hosting communities socially and financially (5,274,296).

There are many positive outcomes from ATD. For example, the use of case management alternatives have proved effective in protecting and improving the health and well-being of migrants, improving compliance, reducing the risk of absconding and supporting fast and prompt case resolution (244,273,274,282,283). There are a number of different measures used to assess whether a specific alternative to detention is considered effective. These include cost-effectiveness, migrants' compliance with migration proceedings, whether the intervention leads to improved case resolution and the impact on the health and well-being of migrants (79). Whether or not these measures are achieved will be influenced by the character of the interventions themselves, which may include the provision of secure living conditions; provision of holistic support, including legal and social support; and providing migrants with regular up-to-date information about their case (244).

In 2020, a pilot study of 126 migrants was conducted in Bulgaria, Cyprus and Poland to evaluate the effect of ATD on migrants (273). The alternatives provided were grounded in IDC's CAP model. Case managers were employed to give support to individuals who were navigating

the migration system in an effort to reach a timely and informed decision (273). The role of the case manager was to form a trust-based relationship with these individuals; support their empowerment; enhance their well-being and problem-solving capacities; and to resolve outstanding issues, both directly and indirectly related to their migration case. Although the case managers did not provide legal advice or services, they did provide information on how to access relevant services (253). One of the advantages of a case management-based approach can be the timely resolution of the individual's case; however, the case manager is independent of the decision-maker and primarily serves as a link between migrants, the authorities and the community (273). Additionally, case managers ensure that the individual has full access to information concerning the immigration process and that they are able to fully participate (273). They also ensure that the government has recent and reliable information about the migrants, with the consent of the individual (273).

The study found that 86% of migrants were still engaged in the case resolution process, only 12% had disengaged or absconded (in Bulgaria alone the rate of absconding was 75% before the pilot study and 18% after the engagement-based intervention), and 2% had been forcibly removed (273). This person-centred approach of case management was the key to the improved mental and psychological health of migrants in that it responded to the unique needs of individuals and allowed them to take a proactive approach and be part of the decision-making process (273). This method offered them a range of basic services including, but not limited to, medicolegal assistance on a one-to-one basis (283). Migrants were thus able to focus on their immigration applications since they could stop worrying about basic needs such as food, clothing, public transportation and medical care (283). Additionally, it fostered a relationship between case workers and migrants built on trust and hope, which enhanced the migrants' general well-being (273). Over 91% of migrants in the study expressed high levels of coping and well-being (273). Similarly, in the United Kingdom, the compliance with immigration processes for migrants who were switched to ATD approaches such as temporary admission, temporary release or bail was 90.8% and 91.9% in 2013 and 2014, respectively (5). Furthermore, following the implementation of a case worker system in Sweden, compliance rates were 63% in 2011 and 68% in 2012 (5). Belgium had similar results after admitting migrant families into family units, with 70–80% engagement, high rates of voluntary return and low rates of absconding (5).

Evidence shows that ATD have a remarkable effect on decreasing financial expenditure for the host country (5,27,83). This is because ID is not cost-effective, in either the immediate or the long-term perspective, and the use of ATD means that ID is either not implemented needlessly or its duration is decreased (5,83,274). In addition to decreasing ID of migrants, ATD also favoured case resolution for migrants. This included assisted voluntary departures over escorted deportations, the former being less expensive and less traumatic for the individual (283), and making ATD more cost-effective and humane (5). Another important factor for the success of case management-based ATD is the use of the casework approach (283). With the case workers' skills and personalities, families can gain trust in the system and be more cooperative during the process regardless of the final decision (244,274,283). This is the case in Belgium, where migrants expressed their appreciation for the caseworkers' efforts (244). Hence, staff recruitment and training, including specific training and/or certifications, must be well planned (283). Moreover, codes of conduct and other rules governing employee behaviour are of utmost importance (283).

3.6.5 Evidence from outside the WHO European Region

Research outside the WHO European Region also supports the benefits of ATD for both the hosting community and migrants. These benefits include reducing future pressure on the health-care system through avoiding issues arising from the often-compromised health of migrants in ID, as well as an almost 80% reduction in expenditure on ID-related activities by reducing the costs spent on building guarded ID facilities (5,298). ATD also ensure the preservation of human rights for all migrants by guaranteeing more humane conditions and improving the integration of migrants into local communities (5,298). They can also enhance the hosting country's infrastructure, through increased investment in basic services such as health and transportation. They have been shown to be more effective in compliance rates (95% appearance rates and 69% independent departure rates) (5,298). Case management and legal assistance programmes can help to achieve efficient and long-term results for immigration processes by instilling trust in the immigration process and avoiding unjustified appeals (5).

ATD provide migrants with more autonomy and freedom of movement (298). Migrants are allowed to buy their own groceries, cook their own food and arrange their own transportation to and from appointments (298). Moreover, they allow migrants the opportunity to socialize and access a support system during their migration process (298). Most noticeably, an Australian study found that the use of ATD improved the mental health of migrants and reduced the rates of self-harm from 260 per 1000 for migrants in ID to 5 per 1000 for migrants enrolled in community-based accommodations (297).

3.7 Strengths and limitations of the review

The main strength of this scoping review is the comprehensiveness of the information that was captured. Although peer-reviewed evidence on ID in the WHO European Region was limited, this was expected and so inclusion of relevant grey literature reports and analyses was critical in order to provide a credible overview of the health outcomes related to ID, the interventions available and the ATD implemented in the Region. From this the evidence-informed recommendations could be created. In total the scoping review was able to identify and narratively analyse over 240 articles/reports, which provided the wide base of evidence used to structure this guide.

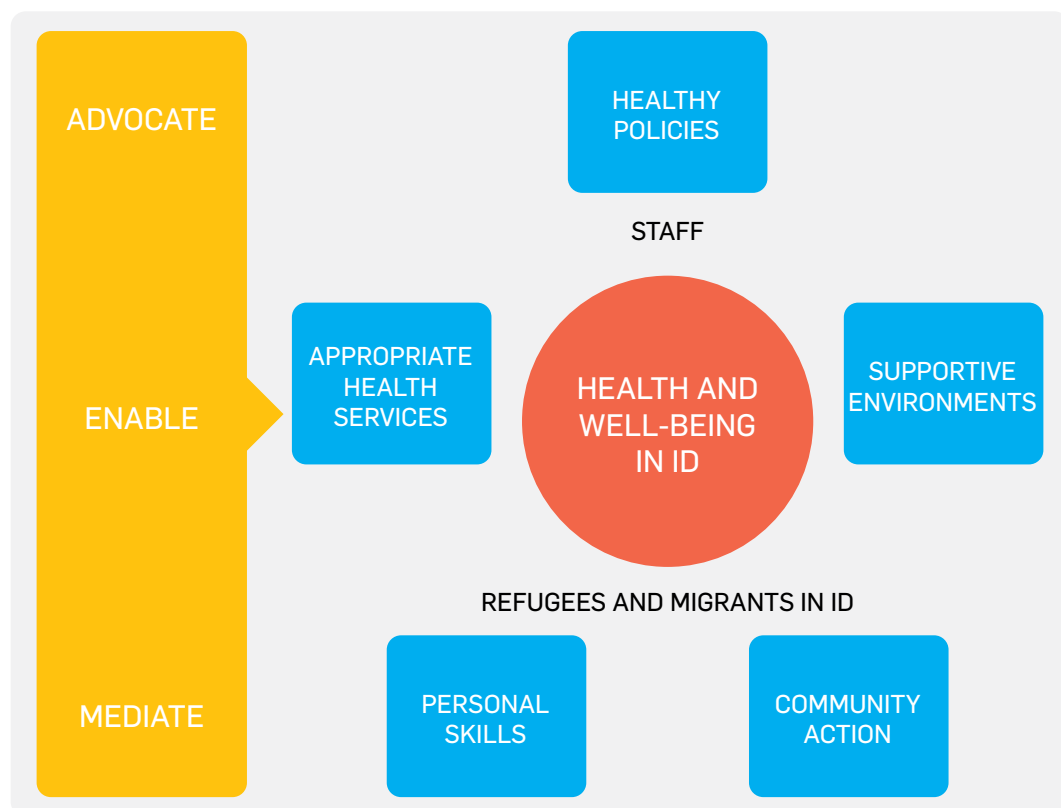
Country reports collected through the grey literature search only captured the most recently published report, this means that recent data were available for some countries while others had not had an evaluation or monitoring visit for over 10 years and, realistically, practices might well have changed since the publication of those older reports. In addition, information that was reported in previous reports but not in the most current report would not be captured by the search and narrative analysis.

The scoping review methodology meant that some relevant studies and/or reports may not have been captured. The search was conducted in multiple languages (Dutch, English, French and Russian), yet many other languages present across the WHO European Region were not included. This means that many national reports, documents and NGO accounts relating to ID have not been captured during the search and subsequent analyses. Regardless, the aim was not to provide a detailed description of ID within every Member State but rather an overview of practices, challenges and approaches to counter the negative effects of ID.

4. The way forward and measures for consideration

The evidence presented in section 3 summarizes the negative impact on the health and well-being of migrants in ID and the factors contributing to this impact. It also highlighted existing measures, including ATD, that mitigate the impact of ID on the health and well-being of migrants. In this section, the Ottawa Charter for Health Promotion will be used to outline the measures that can be taken to address the health challenges in ID (299). The Ottawa Charter for Health Promotion was established in 1986 and explores the factors that can impact the health of an individual (299). It defines health promotion as a means to empower individuals to guide and improve their health and well-being (299). In order to support health promotion, the Charter highlights five action areas: build healthy public policy, create supportive environments, strengthen community action, develop personal skills and reorient health services (299). These key action areas will be adapted to understand what measures can be taken to create a better environment within ID facilities to support the health and well-being of both the detained migrants and staff. The Charter also discusses three key strategies to enable health promotion: advocate, enable and mediate (299); while this will not be explicitly discussed further, they are heavily intertwined and integrated within the measures discussed throughout the five action areas (Fig. 3).

Fig. 3. Health promotion in ID: an interpretation of the Ottawa Charter for Health Promotion



Source: Puthoopparambil, 2016 (269).

Guidelines exist on various aspects that should be considered in ID (1,12,134,198,265,270,272) and the following presents suggestions and practical aspects that could be considered in relation to ID and ATD based on the evidence from the scoping review and existing ID guidelines. These are organized based on the five action points of the Ottawa Charter for Health Promotion (healthy policies; supportive environments; community action; developing personal skills of refugees, migrants and staff in ID; and appropriate health services).

4.1 Healthy policies

The Ottawa Charter emphasizes the link between public policies and the impact they can have on the health and well-being of individuals and communities, regardless of the level at which the policy is directed and whether or not it directly discusses health care (299). A variety of policies impact the health and well-being of migrants in ID, the most important being the migration policies that nations implement to manage immigration (1).

- The **decision to implement ID**, as established in international law, should be taken as a measure of last resort and is to occur after an individual assessment and only when less-coercive measures such as ATD cannot be applied (that is, it should not be a policy instated for all asylum seekers or migrants entering a country or automatic detention); it should be proportional to the circumstances and referenced by the laws of the nation and the ability for legal review (1,36,38).
- **ID for children** is specifically prohibited under international law (13,38,39).
- **Use of ATD and avoidance of ID** whenever possible are clear, with instructions and requirements stated in laws, treaties and guidances (1,28,30,34,36–38,78,205,207,209). As for which alternative to use, States should opt for the least restrictive measures and not infringe an individual's freedom and liberty. As many enforcement-based ATD still infringe an individual's freedom and liberty, ATD should be focused on ensuring positive engagement with migrants through case management-based approaches located within the community (275).
- A **legal basis, need and proportionality** should be used when considering if any ATD are necessary as there are cases where even ATD are not necessary (280,300).
- **Vulnerability screening tools** can help to ensure that ID is only used when necessary. They can guide authorities on whether ID is proportional, limit arbitrary decisions, allow authorities to consider ATD that may be more appropriate or avoid ID altogether (55,198). A vulnerability screening tool has been created by the UNHCR and IDC and comes with supporting guidance on the use and purpose of the tool, as well as the ability to contextualize the vulnerability domains to match national standards and regulations (198,273). Such a tool is also important when trying to understand the health-care needs and individualized support that a refugee or migrant may need if ID is implemented (198,273). **Screening should be offered before a decision is made to detain, but also at regular intervals** if ID is deemed necessary (55,224). The use of a vulnerability screening tool is not enough on its own; systems and/or processes should be established that trigger referral systems and ensure that the proper support is being offered to refugees and migrants (224).

- **Refugees and migrants in vulnerable situations** should not be detained, in line with national and international guidelines, and it should be remembered that the act of being detained per se creates additional vulnerability and risks for every person (198). Each country may have different definitions of what it considers as vulnerabilities, and many have enacted laws that prohibit ID for certain groups and/or have standards of vulnerability or policies that encourage the use of ATD (198). In line with this, the ID of individuals in vulnerable situations should be clearly prohibited by law and there should be individualized screening procedures to ensure that these people are afforded ATD whenever required, based on their case and unique conditions (301). Examples of groups with specific vulnerabilities include, but are not limited to, victims of torture and human trafficking, pregnant women/girls and nursing mothers, elderly people, people with SOGIESC and those with serious health conditions (1,12,29,55,78,198,208,209,233,290,291,301,302). This list of vulnerabilities is not comprehensive, and **decisions on vulnerability should be taken on an individual basis** (55).
- **The rights to health and support systems for refugees and migrants in ID** should form part of policy, which should include incorporating interpreters, cultural mediators and psychosocial assistance into the standard health-care provision packages within ID (78,264,290,303,304).
- The **provision of psychosocial support and mental health care** should also be systematically integrated into ID (130,134,148,198,205). Staffing policies for health-care providers should reflect the numbers and health needs of migrants in ID. Health-care needs are context specific and depend on factors such as country of origin and transit for the refugees and migrants, duration of stay in the host country and the ID environment (305).
- **Data should be systematically collected and be easily accessible** on the number of individuals in ID nationally, as well as the number of refugees and migrants who were enrolled in ATD (280). Countries should strive to ensure that policies ensure transparency and systematic data collection from all ID facilities and any place where deprivation of liberty occurs (as migrants are sometimes detained in prisons and transit zones), with the ability to show disaggregated numbers (for example by age, gender, nationality, basis for ID). Data should be made easily accessible and/or reported on an annual basis at minimum. Clear and accurate data can provide relevant information on trends and provide evidence on the effectiveness of strategies, such as UNHCR's Global Strategy beyond Detention (278).
- **Access to rights and services without discrimination** should be included in all policies (78,192). This means that refugees and migrants in ID should have access to the same public health standards and protocols as implemented in the local community, or equivalence of care should be afforded (247).

4.1.1 COVID-19 and health emergencies

The European Centre for Disease Prevention and Control and WHO have provided guidance on how to support prevention controls in ID for the health of staff and migrants during health emergencies such as the COVID-19 pandemic (184,185). One of the key messages is that

prevention measures offered in the general community should also be instated within ID; this can include physical distancing, testing, clear communication in the relevant languages and personal protective equipment (184,185). The release of migrants in ID into noncustodial settings was advised to increase the space available to practise physical distancing and to make scarce resources more available to all without risking security (78,184,185,191,192,306). Migration proceedings were also recommended to be halted as deportation proceedings were stalled in many cases due to travel restrictions (186). If self-isolation was necessary, it was recommended that it should take place in a noncustodial setting (78).

4.1.2 ATD

International standards reiterate that ID should be the last resort.

- **Legal obligations to examine the use of ATD at all possible instances** should be standardized and developed in all Member States for all, not only for those individuals who may have been screened as vulnerable (12,174,280). Some countries already have these laws in place, but the practical implementation of ATD is less evident.
- **Policies and their implementation should be clarified** (233), for example training staff on the procedures involved with implementation of ATD. When States are considering what ATD they should establish, consideration should be given to employ those approaches with the least restrictions (129,280,296,301). Ideally, these include case management-based approaches located in the community rather than those based on enforcement and control (129,273,275). Alternatives that are offered should have regular monitoring systems in place to ensure safety and well-being, particularly for vulnerable populations, including children (224).
- **Enforcement-based mechanisms**, if used, should be noncustodial and the frequency should not present an overly harsh burden for individuals, for example requiring weekly rather than daily reporting (280,296,301). Mechanisms that resemble punitive or criminal frameworks, including electronic tagging, are alternative forms of detention, rather than alternatives to detention. They have the potential to create further stigmatization of refugees and migrants, as well as severely curtailing liberties and freedom of movement, and are highly discouraged (280). Alternatives that are offered for vulnerable populations, including children, should have regular monitoring systems in place to ensure their safety and well-being (224).
- **ATD should not be used as another arbitrary measure to restrict migrants' liberty** (296). States should consider evaluating the effectiveness of their ATD programmes to ensure they are being used appropriately and only for individuals who would otherwise be detained or at risk of ID (301). Some questions that could be useful for this include the following (280).
 - Do ATD (more enforcement-based measures) stigmatize refugees and migrants within the community?
 - Are ATD implemented only when valid (legal) grounds for ID exist?
 - Are only the most necessary restrictions being imposed upon refugees and migrants and within the context of the international legal frameworks?

- How does the nature of an ATD programme (enforcement-based or engagement-based programme) impact differently the health and well-being of the individuals enrolled in such programmes?

Detailed guidance to ATD is produced by the IDC, IOM and UNHCR (1,5,267,268,307).

4.2 Supportive environments

The environment in ID consists of elements such as the physical environment, provisions and restrictions, social environment and, most importantly, the people: staff, refugees and migrants. Because the evidence clearly indicates that the environment plays a vital role in dictating the health of refugees and migrants in ID, it is important to develop strategies that can be implemented in ID to make environments as conducive as possible for mitigating the negative impacts and safeguarding health. Community-based, noncustodial alternatives will always be best if authorities decide to deprive refugees and migrants of their liberty (275). However, where ID is used by authorities there are some key aspects that should be considered.

4.2.1 The physical environment

The facilities that are used for ID should not create an environment that is punitive (1). Settings should ensure the respect and protection of refugees and migrants and not criminalize refugees and migrants (308).

- **Designated facilities** only should be used for administrative detention; police stations should not be used, nor should refugees and migrants in ID be placed in the same facilities as those detained in the context of criminal justice (1,175).
- **Prison-like characteristics** for facilities should be avoided; this includes barbed wire and uniforms for either staff or refugees and migrants in ID (1,116).
- **Overcrowding** in ID should be addressed as this has been shown to impact migrants' mental health (147), may increase the risk of traumatic events (55,147) and creates an increased risk for the spread of communicable diseases (175,180,182–185,265). Minimum standards for occupancy provided for in national legislation and on the ground should meet international standards (247,248,308).
- **Recreational space** for physical and meaningful activities should be provided within ID facilities and should be accessible on a regular basis (1,232,302). Furthermore, access to an appropriate outdoor area should be provided, offering refugees and migrants in ID the opportunity to get fresh air and natural light (1,232,247,248,302).
- **Gender-sensitive policies** should be initiated (1,55,265). Women should have access to special facilities, and sanitary supplies as necessary (such as sanitary pads) (1,12). Refugees and migrants in ID should be afforded privacy in showers and within bathrooms or any time personal activities are occurring (such as changing clothes).

- **Provision of physical amenities.** Other physical items should be provided to refugees and migrants in ID, such as personal items and basic amenities, which include beds, climate-appropriate bedding, shower facilities and clean clothing (1,78). Water and sanitation may need to be improved in some ID facilities, especially those with large numbers of refugees and migrants and high rates of turnover (78,147). Minimum standards for hygiene conditions should always match or exceed international standards (247,248,308).

4.2.2 Staff

Staff are an integral part of the ID environment and dictate how much support and guidance a refugee or migrant will receive.

- **Staff recruitment** should carefully choose and recruit people for their integrity, humanity, professional capacity and personal fit for working in ID (12). It is best if members of staff have different cultural and professional backgrounds. As language barriers hinder access to services for migrants in ID, it is helpful if staff members can speak a variety of relevant languages (12,304). The recommendation still stands that no families should be detained for migration matters, yet States still do so. Female staff should be hired in general but are particularly desirable in ID facilities that house women and families (1,12). Increasing engagement between staff and migrants in ID enables staff to address the emotional and practical needs of refugees and migrants in a respectful manner (12,232,304).
- **Roles among staff members** should be clearly established and delineated in ID as this is beneficial in ensuring that responsibilities do not overburden staff or create ethical dilemmas. The scope of staff tasks should be clear and consistent in manner (see Case study 6) (12,115,173,232). Staff must comply with international standards, and codes of conduct should be signed and adhered to (1,309).
- **Staff numbers** should be adequate and maintained to support refugees and migrants. Staff should be provided with appropriate and timely training when starting employment and with refresher courses during their employment (see section 4.4).

4.2.3 ID provisions and restrictions

Certain other provisions should be provided for all refugees and migrants in ID. Importantly, communication within ID must be accessible to all.

- **Appropriate communication methods** include providing information in a language that is understood by refugees and migrants in ID, and using professional interpreters during meetings and information sessions. Provisions should also be made for migrants with varying levels of literacy (for example, using graphic symbols, videos and audio materials) (310). All refugees and migrants in ID should be provided with information on why they are being detained, expectations while in ID, what services are available to them (especially their rights to health care) (255) and clear communication about their length of stay (28,115,205). Provisions should be made for migrants who are illiterate.

- **Legal assistance** should be available for all refugees and migrants in ID (1,123). Lawyers should have access to refugees and migrants, and confidentiality should be preserved (1,123).
- **Ability to communicate with the outside world** should be provided with sufficient resources and opportunities within facilities; this would include family visits and receiving or making phone calls through the use of phone booths or providing appropriate cell phones (1,78,116). This may also mean having computers or other means available through which refugees and migrants in ID can access the Internet and communicate with friends and family (1,116,265).
- **A reporting process** should be available so that refugees and migrants have the possibility to submit complaints (for example on any safety incidents such as abuse or maltreatment) in an efficient and safe manner, without any fear that submitting a report will impact their migration case or elicit poor treatment from authorities because complaints were filed (12). These complaints should be duly investigated and addressed in a timely manner.
- **Good-quality food** should be provided that is not only nutritious but also culturally and religiously appropriate (1,116,144,232). Meal times could also be more flexible to accommodate the needs of all (such as individuals with special needs) (78,116,232,302). Special diets should be provided for pregnant and breastfeeding women, and individuals with special needs (1).
- **Meaningful activities** should be provided daily; this is especially helpful in supporting the mental and physical health of refugees and migrants in ID. A variety of activities can be provided; appropriate access to outdoor spaces and the ability to be physically active is important. Further, facilities can provide educational activities (such as language classes or health education) and can also provide books, newspapers and board games (1,265,301). In certain facilities other opportunities like paid work may be appropriate (116).
- **ID environments should maintain only any necessary restrictions** to ensure the safety of refugees and migrants in ID. Any measures that resemble punitive or prison-like systems should be discouraged; these include (115,129):
 - locking in individuals overnight
 - limiting access to outdoor spaces, activity rooms and communication channels
 - the use of high-security fences or barbed wire
 - extensive surveillance that is not deemed necessary to maintain security (144)
 - refugees and migrants in ID required to wear uniforms (1)
 - the use of solitary confinement, (232,291).

4.2.4 Screening for vulnerable people

ID in and of itself creates a vulnerability for all refugees and migrants and, as such, care must be provided within ID to counteract the harmful impacts of being detained. Vulnerability is assessed at an individual level and particularly vulnerable groups have been identified that may need specialized care if detained (198).

- **Vulnerability screening** should be carried out for all individuals before they enter ID to understand the special needs and support that an individual might need (see section 4.1).
- **Revisiting screening** over time can ensure that the needs of the refugee or migrant have not changed and can assess whether ID is still the most appropriate measure (198).

The measures following are important for supporting the needs of those who fall into the most commonly accepted domains of vulnerability (198) and may also be important for individuals who are vulnerable but do not fall into these pre-defined categories.

4.2.5 Children as a vulnerable group

- The **detention of children** for migration-related matters is clearly prohibited under international law and must be avoided at all costs (13,38–40,265). However, children are detained in the majority of the Member States of the WHO European Region and, therefore, authorities should take greater responsibility to uphold high standards in ID.
- **Families with children** should be kept together. If a State detains families, then the separation of children from their family against their will is to be avoided (12,78,290). Optimally, families should not be detained but offered ATD. Children should never be placed in the same ID centre as adult migrants unless with their family (12,311), and if with family in a separate or special wing of the ID facility.
- **Unaccompanied children** should ideally be provided with guardianship by a family member who already has residency within the asylum country (1,78), taking into account appropriate child-safeguarding measures. If this is not available, the competent childcare authorities should make alternative care arrangements, such as foster placement or residential homes, which must cater to the child's optimal growth, while longer-term alternatives are being investigated (1,78,264,290). An independent and qualified guardian as well as a legal adviser should be appointed for the unaccompanied child (1,12,290). The child should also be enrolled in a process which allows for the possibility of family reunification (12,174).
- **Where children are detained in facilities**, cultural considerations should be made in relation to the activities that are provided (1,290). The right to receive education is essential for the proper development of a child. Preferably, educational activities should be offered outside of the ID premises to facilitate the continuation of their education upon release (1,290). Other activities should include the ability for recreational and playtime, alone and with other children, as a strategy to cope with stress and trauma and to provide adequate opportunities for development and growth for the child (1).

4.2.6 Provisions for others in vulnerable situations

ATD should be offered to all refugees and migrants, except in exceptional circumstances. If those exceptional circumstances do exist then those refugees and migrants with diverse SOGIESC, women and families should be offered separate facilities in ID (1,12,292).

- **Safeguards** should be implemented that focus on preventing sexual and gender-based violence and exploitation (1,12). If abuse happens while in ID then immediate protection, support and counselling should be provided and claims should be investigated by an independent authority (1,292). Specialized health care should also be afforded to migrants with SOGIESC (292).
- **Pregnant women, girls and mothers** should be provided with specialized care that ensures that continuity of pre- and postnatal care is readily available in ID (143,144,214). Meal times should be flexible, and enough food should be provided to ensure the dietary needs of pregnant and nursing women are met (144).
- If **refugees or migrants with disabilities** are detained by a State, which should be avoided, it is necessary that ID provide accessible accommodations or changes ID practices to match their specific requirements and needs (1). Alternative arrangements may need to be tailored to their specific needs, such as telephone reporting for people with physical or intellectual disabilities (1,12).

4.3 Community action

The Ottawa Charter describes community action as “the existing human and material resources in the community to enhance self-help and social support” (299). Within the context of ID, community resources may relate to the NGOs, national and international agencies, independent agencies that advocate, monitor or provide services to refugees and migrants in ID.

- **Good coordination and networking** should occur between organizations to allow for the exchange of information and good practices between all structures and services involved, including national authorities, international agencies, independent organizations/agencies (such as an ombudsman), NGOs and civil society organizations (78,180,232,264,304,312). This could be facilitated through the creation or strengthening of working groups and committees that are built with all stakeholders involved in supporting and interacting with refugees and migrants in ID.
- **Regular, independent monitoring** of conditions and treatment should be carried out and appropriate solutions to identified issues should be implemented. Monitoring systems are an important resource that is essential in ensuring international standards are met and safeguards for refugees and migrants are in place within ID (12). Monitoring can support two key functions: prevention (finding adaptations that will better ensure human rights are safeguarded) and correction (showing where improvements are needed based on events that are observed or reported) (12). To support this, independent working groups or committees should be responsible for conducting regular investigations to explore the conditions in ID, particularly regarding health impacts, health provisions and the ability of refugees and migrants in ID to exercise their rights (29). Working groups should consist of a diverse group of stakeholders such as governmental officials, NGOs and international migrants themselves (where feasible). Access to all ID facilities should be provided to independent national, international and regional bodies (such as CPT, the International Committee of the Red Cross, UNHCR and WGAD) upon request and as set out by international standards,

whether as scheduled or as unannounced inspections (1,174,232,290). Facilities managed by private contractors must comply with these conditions, most importantly to ensure that national and international standards are complied with, and evaluations should impact whether a contract is renewed or not by the State (1,79).

- **Monitoring evaluations** should be compiled into reports that are transparently shared, published in a timely fashion and provide practical recommendations that should be discussed and presented to ID management and/or policy-makers (272). These monitoring mechanisms can also help to set and adjust the standards for ID. As outlined in section 3 on the findings of the review, there are only a few guides that provide details on how to conduct a comprehensive evaluation during a monitoring visit (12,270,272). These guides could be further improved based on guidelines that exist for other populations that share some similar characteristics (313).
- **Accountability mechanisms** should be established to ensure that issues and recommendations presented to migration authorities during monitoring visits are implemented in a timely manner. Monitoring bodies should work with ID authorities to facilitate the implementation of recommendations.
- **Standardized monitoring and evaluation tools and practices** should be created to collect data on common indicators, thus enabling comparisons at national, regional and global level to identify trend data on ID and ATD (269). Although monitoring evaluations are currently ongoing in all Member States in the Region (such as CPT and NGO monitoring), current practices mean that these evaluations are not standardized in any way, limiting the functionality of what can be accomplished. Ideally, evaluations would capture the entirety of what is recommended within the guidance currently available (12,270,272), including the number of refugees and migrants in ID every year and their corresponding demographics. Most importantly, from a health and well-being perspective, details relating to health-care provisions, ID environment and psychosocial support should be evaluated as a minimum and reported annually. This is important in order to evaluate and adjust needs, as the health and well-being of refugees and migrants in ID are important from a human rights perspective but also in relation to the public health needs of the community. Preventing deteriorating health early on will also cost less for ID facilities overall and can limit any delays that adverse health effects may have on immigration procedures (198).
- **Enhanced collaboration between the staff in ID and volunteers** (including NGOs, health-care providers and other external agencies) would help to support stronger community action. Their involvement and services can be developed further to support both the staff in ID as well as the refugees and migrants (129,301,305). NGOs and outside agencies need to have both access and the opportunity to provide services in ID that offer psychological support for refugees, migrants and staff, plus access to other social services that ID management may be unable to provide themselves. It is important that such organizations have full access and the ability to set up support systems in an independent manner in ID, thus providing their services and sharing knowledge with both staff and administration in order to foster an environment that supports the health and well-being of all (55).

- **Academic institutions** can also support the needs of this community by providing much-needed evidence on the health-care needs and challenges and ATD opportunities. Researchers need access to ID and resources to study health and well-being in ID. This review has highlighted the overwhelming gaps in the literature (see Fig. 1 and section 3.7) in that only a handful of countries have conducted studies directly within ID. More systematic and longitudinal studies need to be conducted to mitigate negative impact within ID and after release from ID (177), and to also explore ATD. Studies that implement and evaluate interventions need to be conducted, specifically targeting factors that are associated with the poor health that refugees and migrants in ID experience (30). ID is not a widely studied topic within migration research, especially the health aspect. Funding agencies also need to prioritize ID, along with the other health challenges faced by refugees and migrants. Efforts to improve awareness among researchers and the wider community about health challenges in ID should be implemented.
- **Community-based ATD and support models** should be increasingly utilized. Research on ATD, and specifically the impacts on health and well-being, needs to be conducted to provide the evidence base to support informed decision-making by policy-makers. More community resources and funding are also needed to ensure that both human resources and services are sufficient to enable ATD programmes to expand (78,174,233,302,303,311,314).

4.4 Developing personal skills of refugees, migrants and staff in ID

The Ottawa Charter promotes the use of personal development as an avenue through which individuals can “exercise more control over their own health”, which can be supported by health education and skill development (299).

- **Personal skills of refugees and migrants** can be developed in ID if they are there long enough for personal skills and courses to be offered that could support their health and well-being. Ideally, stays will be very short; however, in some countries the average length of ID can be at least a few weeks to months. In such scenarios, offering programmes and courses that could enable refugees and migrants in ID to handle the stress and pressures inherent to detention would be essential. This could be structured as psychological support groups (as mentioned in section 3.5.1). These can provide refugees and migrants in ID with personal skills to handle their emotional responses better; de-stigmatize mental health support; help migrants to understand how to interact more constructively with others; and provide an avenue for shared experiences (215). As recommendations are centred on ensuring that the duration of ID is minimal, the goal would be that individuals are not detained for a length of time in which courses and classes would be necessary or practical. Instead, psychosocial skills and coping mechanisms could be taught in abbreviated formats (for example, via brochures providing practical tips for refugees and migrants in ID regardless of staff resources or length of stay in ID) (215).
- **Timely skill development for staff** working in ID is paramount, as their interactions with those in the facility will be highly contributory to the experience and support those refugees and migrants will receive. As the evidence has indicated, employees report high

levels of stress and often fear and, consequently, should have prompt and unrestricted access to feedback, psychosocial support sessions and counselling services (12,78,304). Access to comprehensive and timely staff training would also ensure that ID staff are better prepared to handle their roles, understand the population group that they are interacting with, the standards they should adhere to and how to ensure the safety of those in ID and themselves from a physical and mental health perspective. Comprehensive staff training does not only support staff health and engagement but also provides better support and services to refugees and migrants in ID (28,115).

- **Health-care staff training** should include:
 - information on the Istanbul Protocol for all health-care professionals who perform medicolegal examinations for refugees and migrants, whether in ID or within hospitals (197);
 - mental health needs of refugees and migrants in ID, which is necessary and currently lacking (33);
 - working with a multicultural population that is deprived of liberty (233); and
 - information and support for addressing the ethical dilemmas that might arise (233).
- **Training for all staff working in ID** should include:
 - an understanding of the key mental health symptoms, how to recognize indications of poor mental health and the steps for referring refugees and migrants in ID to specialized mental health care (12,33,209,232,303,304);
 - first aid, infectious diseases and, if vulnerable populations such as pregnant women are detained, specialized training on their specific issues (such as obstetric emergencies) (144,264);
 - information on asylum procedures, sexual and gender-based violence, people with diverse SOGIESC and human rights standards (1,12,192,292,303,304);
 - nonviolent communication, which is important for all staff employed in ID;
 - areas of child protection and safeguarding in States that detain children for migration-related purposes (12,232,303); and
 - how to manage their own stress and what supports are available to them (12,115,232,312).
- **Cultural competencies** (312) that would be beneficial for all staff include:
 - critical awareness, which allows staff to reflect on their own cultural backgrounds;
 - capacity-development to act in culturally diverse contexts;
 - social justice values; and
 - organizational support that can empower them.
- **Support for all staff** is needed to help them to address the ethical and emotional dilemmas they might face while working in ID. NGOs providing services in and/or for ID, such as the British Medical Association (233), can provide resources, guidance and training on how to approach ethical dilemmas in ID for staff. Online training and support from management can help staff in knowing how to raise concerns in the workplace (233).

4.5 Appropriate health services

The health services most often provided in ID are centred on purely clinical services and not preventive health care. The Ottawa Charter encourages a shift to more preventive measures that respects the cultural needs of the local population (299). In general, a more holistic model of health care should be provided in ID. This should be centred around the many factors that are associated with the well-being of refugees and migrants in ID and should incorporate the various actors involved in supporting refugees and migrants in ID (255).

- **Needs-based access to free medical care** should be available for all refugees and migrants at the earliest possible opportunity, and on an ongoing basis (12,78,175,192,272,290,312), in accordance to their right to health care (15). All individuals in ID should have access to the same preventive health screening and health care as that provided in the host community: the equivalence of care (12,78,290). Specialized health services should be provided and planned based on the needs of refugees and migrants in vulnerable situations, including children and pregnant women (12,144,290).
- **Transfer to appropriate health facilities** should occur for all refugees and migrants in ID who require medical care if such care is not available in the ID facility (1,12,272).
- **Psychosocial services** need to be provided within ID, including screening upon admission and access to mental health-care treatment (33,137,147). The mental health-care support should incorporate the use of psychological talking therapies and not just medications, as this is seen as a major gap in the current services provided (204).
- **Where ID facilities lack funds or staff to provide all necessary services** United Nations agencies and NGOs should be asked to provide adequate physical and mental health care for refugees and migrants (290).

4.5.1 Health-care support and interventions that meet key ethical principles

- **Health-care providers should have independence and autonomy** in their diagnosis and treatment decisions (12,255,272). This implies that ID staff should not be responsible for handling health-care requests and should not be in charge of dispensing medications, as has been reiterated by CPT monitoring visits (90,132,152).
- **Sufficient health-care providers** should be provided to ensure that adequate levels of care can be provided to the number of residents involved (12,264).
- **Priorities and responsibilities** should be aligned between health-care providers and other ID staff to limit delays in care or inadequate quality of care. This may relate to ensuring escorts and vehicles are available if refugees and migrants in ID need special care outside of the facility, or if medical screening needs to be coordinated with staff (305). Medications should be easily accessible, handled by health-care professionals, stored safely and disposed of when expired (12,304). Medications should not be the only health-care treatment offered in place of other appropriate treatments and medical services (272).

- **Evidence-informed protocols** should be in place for ID and health-care providers on the clinical management and care system for refugees and migrants in ID (1,12,184,233,265).
- **Health screening** should be systematically integrated in ID to shift towards the more preventive health-care model that the Ottawa Charter encourages. Medical screening (for both physical and mental health) should always be provided to any one arriving at an ID facility. In addition, **regular assessments** should be conducted even if no symptoms were apparent upon arrival, because being detained can have psychological and physical repercussions (1,12,198,272,302,303). Screening will support not only the refugees and migrants in ID, providing better knowledge on what their health needs are, but also ensure that other individuals, such as staff or visiting NGO personnel are protected from any communicable diseases (1,12,78,115,146,174,264,272,290,304,311). The evidence shows that medical screening is often not widely implemented, not comprehensive or is provided by health-care workers who are not trained well on the screening procedures. More specialized training and support needs to be offered to health-care providers working in ID to support screening and control of communicable diseases and NCDs (305). Screening should:
 - incorporate tests for a broader number of infectious diseases, including TB, HIV and hepatitis A, B and C (178);
 - ideally try to complete immunity and vaccine records for preventable diseases to help to prevent disease outbreaks (160);
 - be considered as a single comprehensive health check for all key diseases listed above and an overall health history (for example, history of NCDs) as this would help to decrease the stigma often associated with health screening (146);
 - use culturally sensitive assessments and take into account the possibility of torture or trauma history (12,174,233,272,302,304,311); and
 - should be conducted by competent and adequate health-care professionals (1,12,78,264,272,303,304).
- **Follow-up health-care services** should be provided for any health issues identified through screening. To ensure that screening leads to better support and services for refugees and migrants, guides like the Vulnerability Screening Tool suggest that staff should receive training on referral pathways, and discussions should be held on what services need to be integrated within an ID facility to provide holistic levels of support (198).
- **Continuity of care** needs to be ensured through the use of robust reporting across community health-care networks and within ID (264,305). The use of a unique identifier would ensure that refugees and migrants who are moved between ID facilities, and those receiving secondary and tertiary health-care services, can receive better continuity of care (178). Upon arrival to ID, each refugee or migrant should have their personal comprehensive medical record started (272,304), and this should be updated throughout their stay and made accessible to community health services, and the individual upon release (240).

- **A data-sharing system** would facilitate the process of sharing health data between ID facilities and authorities within a country, and eventually between countries (264), in line with current international data-sharing laws (such as the EU's General Data Protection Regulation). Overall, there is a need for better data on the health and health needs of refugees and migrants in ID; this calls for more robust data collecting within ID (155) not only related to health but also to the demographics and inflows of refugees and migrants detained (314). As this is sensitive information, measures should be taken to safeguard all data. Therefore, informed and explicit consent should be obtained from refugees and migrants (315), and data should be anonymized after being collected (for storing purposes) (316). Clear protocols should exist on who has access to these data and how they will be used; this information should be relayed back to the refugees and migrants in ID (186,317). Ideally, the health-care data for ID would be integrated with the public health systems serving the community.
- **Stronger referral pathways** between ID facilities and local health systems would help in the provision of needed specialized health care for refugees and migrants in ID (12,78,264,272,304). A lack of referral system was often cited as a reason why health care was delayed or inaccessible to migrants.
- **Vaccine provision** should be ensured for all health-care workers and staff in ID, and for refugees and migrants when required in order to limit outbreaks of vaccine-preventable diseases (179,265). If an outbreak occurs in the country/area, vaccines should be quickly provided to any at-risk refugees and migrants in ID in order to break the train of transmission (147,160,179). In some cases, the use of mathematical modelling can support the management of communicable diseases when outbreaks do occur in ID (see section 3.5.1). Modelling can help management of an ID facility and health-care providers to decide on the appropriate public health measures to enact (160). To support the management of potential outbreaks, vaccine records and screening on immunity of staff working in ID should also be up to date and readily available (160).

4.6 Overview of key measures for consideration

Healthy policies

- Use ATD, with use of ID as a last resort; there should still be a legal basis, need and proportionality used when considering if any ATD are necessary; in addition
 - prohibit ID for children;
 - always use ATD for children and families, whenever legal grounds for ID exist;
 - standardize and develop a legal obligation to examine the use of ATD during all instances where authorities consider using ID;
 - train staff on the procedures involved with implementation of ATD; and
 - employ ATD with the least number of restrictions.
- Perform individual assessments before determining if ID is to be implemented.
- Use a vulnerability screening tool to guide authorities on whether ID should be applied or not, and whether ATD would be better.

- Detention of vulnerable individuals should not occur.
- Strengthen the right to health and support systems for refugees and migrants in ID, including the provision of psychological health care.
- Provide transparency on the number of individuals in ID nationally, as well as the number of refugees and migrants enrolled in ATD. Data should be systematically collected, able to be disaggregated and made easily accessible.
- Ensure access to rights and services without discrimination.

Supportive environments

- Use only designated facilities for ID; police stations should not be used, nor should refugees and migrants be placed in the same spaces as prisoners.
- Avoid any prison-like characteristics.
- Address overcrowding in ID, especially in relation to its links with the risk and spread of communicable diseases and impact on mental health for those detained.
- Ensure the accessibility of physical and recreational spaces on a regular basis.
- Initiate gender-sensitive policies.
- Recruit and hire staff carefully for their integrity, humanity, professional capacity, and personal fit for working in ID.
- Establish clear and delineated roles for ID staff.
- Maintain adequate numbers of staff.
- Provide sufficient resources and opportunities for refugees and migrants to communicate with the outside world.
- Provide meaningful activities daily.
- Maintain only the most necessary restrictions in ID to ensure the safety of refugees and migrants in ID.

Community action

- Ensure the increased use of community-based ATD and support models.
- Ensure coordination and networking between organizations to allow for the exchange of information and good practices.
- Create or strengthen working groups and committees comprising all stakeholders involved in supporting or interacting with refugees and migrants in ID.
- Carry out regular, independent monitoring of conditions and treatment in ID and ensure that appropriate solutions to issues identified are implemented:
 - share reports transparently, and publish them in a timely fashion;
 - establish accountability mechanisms to ensure that issues and recommendations presented to migration authorities during monitoring visits are implemented in a timely manner; and
 - implement collaborations between monitoring bodies and ID authorities to facilitate the implementation of the recommendations.
- Create standardized monitoring and evaluation tools that collect data based on common indicators.

- Ensure NGOs and outside agencies have access and possibility to provide services within ID.
- Provide access to ID and resources to researchers to study health and well-being in ID.

Developing personal skills of refugees, migrants and staff in ID

- Offer programmes and courses that could enable refugees and migrants in ID to handle the stress and pressures that inherently come with being detained.
- Ensure timely skill development of staff working in ID, including training on first aid, medical needs of refugees and migrants, asylum procedures, cultural competencies and non-discriminatory treatment.
- Ensure prompt and unrestricted access to feedback, psychosocial support sessions and counselling services for staff in ID.

Appropriate health services

- Establish needs-based access to free health care for all refugees and migrants in ID, at the earliest possible opportunity, and on an ongoing basis.
- Move refugees and migrants who require health care to appropriate facilities if such services are not available in ID and establish strong referral pathways.
- Ensure access to essential medicines within ID.
- Provide adequate psychosocial services within ID.
- Ensure health-care providers have independence and autonomy in their diagnosis and treatment decisions.
- Ensure that priorities and responsibilities are aligned between health-care providers and other ID staff.
- Use evidence-informed protocols to prevent further harm.
- Integrate comprehensive health screenings within ID:
 - provide appropriate health-care services for the health challenges identified through screenings; and
 - regularly screen refugee and migrants for both physical and mental well-being.
- Implement robust reporting to ensure that continuity of care is managed across community health-care networks and within ID.
- Institute measure to collect data on ID and ATD and take measures to safeguard data
- Facilitate the process of sharing health data between ID and authorities within a country, and eventually between countries.

5. Conclusions

Despite the poor health that is experienced by migrants in ID, and the high costs associated with it, States actively use ID as a migration management tool despite international guidelines and laws. The environment in ID leads to the declining mental health of migrants, relating to the multitude of stressors that they experience. The environment is also a risk factor for the spread of communicable diseases. While ID varies greatly among and within Member States, conditions often do not reflect the administrative nature of ID, with many facilities mimicking prisons and their regimes yet without providing the safeguards and provisions found in prisons. It is important to identify measures to mitigate the negative impacts of ID on the health of refugees and migrants, while encouraging efforts to minimize the use of ID, promote the use of ATD and moving ID to be truly the last resort.

The recommendations made from this review of the evidence offer insight into five key themes from the Ottawa Charter for Health Promotion and how these can be adapted to alleviate the health impacts of ID. Healthy policies promote the better use and implementation of ATD with an aim for Member States to promote the use of ATD and avoid ID whenever possible. If States do detain refugees and migrants then section 4.2 (supportive environments) lists key standards to ensure that ID limits restrictions and provides an environment that enables the health and well-being of refugees and migrants. Community action calls for better collaboration between stakeholders, including regular monitoring of ID as a preventive measure to safeguard the health of refugees and migrants. The well-being of refugees and migrants is impacted by how supportive staff are in ID; consequently, developing personal skills focuses on the requisite training staff need to receive to perform their duties with the needs of refugees and migrants in mind. Finally, the appropriate health-care section lays out Member States' duty of care to provide needs-based access to free medical care as well as the necessities of comprehensive medical screening and incorporating psychological health-care.

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Recommended reading

Specific for ID

Detention guidelines: guidelines on the applicable criteria and standards relating to the detention of asylum-seekers and alternatives to detention. Geneva: United Nations High Commissioner for Refugees; 2012 (<https://www.unhcr.org/uk/publications/legal/505b10ee9/unhcr-detention-guidelines.html>, accessed 21 December 2021).

Guidelines for border management and detention procedures involving migrants: a public health perspective. Geneva: International Organization for Migration; 2010 (<https://www.iom.int/sites/g/files/tmzbd1486/files/jahia/webdav/shared/shared/mainsite/activities/health/Guidelines-Border-Management-and-Detention-Procedures-Public-Health-Perspective.pdf>, accessed 21 December 2021).

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Monitoring immigration detention: practical manual. Geneva: Association for the Prevention of Torture; 2014 (<https://www.apr.ch/en/resources/publications/monitoring-immigration-detention-practical-manual-2014>, accessed 21 December 2021).

NGO monitoring of immigration detention: tips, examples and positive practices. Melbourne: International Detention Coalition; 2015 (https://idcoalition.org/wp-content/uploads/2016/07/IDCReport_NGO-Monitoring-and-Immigration-Detention_cover1_22Dec-2.pdf, accessed 21 December 2021).

The Istanbul protocol. Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment Geneva: Office of the United Nations High Commissioner for Human Rights; 1999 (https://phr.org/wp-content/uploads/2020/11/istanbul-protocol_opt.pdf, accessed 21 December 2021).

UNHCR's learning initiatives on the immigration detention of asylum-seekers and refugees. Geneva: reliefweb; 2019 (<https://reliefweb.int/training/3004079/unhcr-s-learning-initiatives-immigration-detention-asylum-seekers-and-refugees>, accessed 21 December 2021). [This gives an overview of an e-learning course, Fundamentals of Immigration Detention, and two thematic self-study modules on immigration detention monitoring and on alternatives to detention, with links to access these.]

Visiting immigration detention centres: a guide for parliamentarians. Strasbourg: Council of Europe; 2013 (<https://edoc.coe.int/en/migration/7535-visiting-immigration-detention-centres-a-guide-for-parliamentarians.html>, accessed 21 December 2021).

Visiting places of detention. What role for physicians and other health professionals? Geneva: Association for the Prevention of Torture; 2008 (<https://www.apr.ch/en/resources/publications/visiting-places-detention-what-role-physicians-and-other-health>, accessed 21 December 2021).

Vulnerability screening tool: identifying and addressing vulnerability – a tool for asylum and migration systems. Geneva: United Nations High Commissioner for Refugees; 2016 (<https://www.unhcr.org/protection/detention/57fe30b14/unhcr-idc-vulnerability-screening-tool-identifying-addressing-vulnerability.html>, accessed 21 December 2021).

Communicable disease prevention

Guidance on infection prevention and control of coronavirus diseases (COVID-19) in migrant and refugee reception and detention centres in the EU/EEA and the United Kingdom. Stockholm: European Centre for Disease Prevention and Control; 2020 (<https://www.ecdc.europa.eu/sites/default/files/documents/COVID-19-guidance-refugee-asylum-seekers-migrants-EU.pdf>, accessed 21 December 2021).

Preparedness, prevention and control of COVID-19 in prisons and other places of detention: interim guidance 8 February 2021. Copenhagen: WHO Regional Office for Europe; 2021 (<https://apps.who.int/iris/handle/10665/339830>, accessed 21 December 2021).

ATD

Advocating for alternatives to migration detention: tools series No. 2. Geneva: International Organization for Migration; 2021 (<https://publications.iom.int/books/advocating-alternatives-migration-detention-tools-series-ndeg2>, accessed 21 December 2021).

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Captured children: introducing a new model to ensure the rights and liberty of refugee, asylum seeker and irregular migrant children affected by immigration detention. Melbourne: International Detention Coalition; 2012 (<https://idcoalition.org/wp-content/uploads/2017/04/Captured-Childhood.pdf>, accessed 21 December 2021).

IOM road map on alternatives to migration detention: tools series No. 1. Geneva: International Organization for Migration; 2019 (<https://publications.iom.int/books/iom-road-map-alternatives-migration-detention-tools-series-ndeg1>, accessed 21 December 2021).

Options paper 1: options for governments on care arrangements and alternatives to detention for children and families. Geneva: United Nations High Commissioner for Refugees; 2015 (<https://www.unhcr.org/uk/protection/detention/5538e4e79/unhcr-options-paper-1-options-governments-care-arrangements-alternatives.html>, accessed 21 December 2021).

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Annex 1. Search strategy

Search protocol

Five academic databases (Cumulative Index Nursing and Allied Health Literature (via EBSCOhost), MEDLINE (via PubMed), PsychInfo (via EBSCOhost), SCOPUS and Web of Science Core Collection) were searched on 1 July 2021 for peer-reviewed literature published in English on the health outcomes, needs and challenges of refugees and migrants detained in ID facilities or ATD in the WHO European Region. Three members who spoke Dutch, French or Russian ran additional searches between 1 July and 30 July 2021 in eLibrary.ru as well as the five databases for Dutch and French articles.

To supplement the peer-reviewed literature, a search for grey literature was conducted in English in July 2021 via Google, Relief Web and Semantic Scholar using shortened and modified search terms. The electronic fund of normative and legal documentation, Consortium “Kodeks” and the Centres for Normative and Technical Documentation Network (CNTD.ru) were also searched. The websites of international organizations were hand-searched to find any relevant articles and reports in English: the Asylum Information Database, CPT, Doctors without Borders, Global Detention Project, IDC, International Committee of the Red Cross, IOM, Médecins Sans Frontières, Office of the United Nations High Commissioner for Human Rights, Association for Prevention against Torture, UNHCR and WHO. Searches were also conducted in July 2021 in Dutch (via Google), in French (via Google) and in Russian (via Google Scholar).

Search terms

Table A1.1 provides an overview of the search terms and categories used during the initial search strategy. Search terms related to the population “refugees and migrants” were adapted from previous literature reviews and earlier Health Evidence Network synthesis reports. The search terms related to “staff” were omitted later to improve the sensitivity of the search.

A pilot search was conducted via Scopus using the population, intervention, control and outcomes (PICO) concept blocks. Search terms within each were combined with the Boolean operator “OR” and then combined with the other blocks using the operator “AND”. Searches were not limited by publication data but were limited by language (English). This search strategy was then adapted to the other websites and databases and was also run individually by other team members in the Dutch, French and Russian.

Table A1.1 Search terms

CONCEPT BLOCKS	SEARCH TERMS
Population	Asylum* OR "asylum seeker" OR "non-national" OR "new arrival" OR refugee OR migrant OR immigrant OR (irregular migrant) OR (illegal migrant) OR migrat* OR undocumented OR foreign*
Phenomenon of interest	Health OR well-being OR wellbeing OR Ill OR illness OR disease
Context	(detention OR detain* OR ("reception cent*") OR ("asylum cent*") OR ("accommodation cent*") OR incarcerat* OR imprison* OR ("removal cent*") OR ("transit cent*") OR ("processing cent*") OR prison OR jail OR ("holding cent*")) OR ((alternatives to detention) OR (alternatives to immigration detention))
Region	Europe* OR EU OR "European Union" OR "European Economic Area" OR EEA OR "WHO European Region" OR "eastern Europe" OR "Baltic States" OR Czechoslovakia OR Albania* OR Andorra* OR Armenia* OR Austria* OR Azerbaijan* OR Belarus* OR Belgium OR Belgian OR "Bosnia and Herzegovina" 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 Georgia* OR German* OR Greece OR Greek OR Hungary OR Hungarian OR Iceland* OR Ireland OR Israel* OR Irish OR Italy OR Italian* OR Kazakhstan* OR Kyrgyzstan* OR Latvia* OR Lithuania* OR Luxembourg* OR Malta OR Maltese OR Monaco* OR Montenegro* OR Netherlands* OR Holland OR Dutch OR "North Macedonia" OR Macedonia OR Norway OR Norwegian OR Poland OR Polish OR Portugal OR Portuguese OR "Republic of Moldova" OR Moldovan OR Romania* OR Russia* OR "San Marino" OR Serbia* OR Slovakia* OR Slovenia* OR Spain OR Spanish OR Sweden OR Swedish OR Switzerland OR Swiss OR Tajikistan* OR Tajik OR Turkey OR Turkish OR Turkmenistan* OR Ukraine* OR "United Kingdom" OR England OR English OR Scotland OR Scottish OR Wales OR Welsh OR "Northern Ireland" OR "Northern Irish" OR Uzbekistan* OR Uzbek
Combining searches	Population and phenomenon of interest Context and region

Study selection

The inclusion and exclusion criteria were the same for both peer-reviewed and grey literature.

Inclusion criteria:

- published in Dutch, English, French or Russian;
- focused on the context of ID (migration-related, and closed facilities) or ATD;
- pertaining to the population of refugees or migrants;
- focused on at least one of the 53 WHO European Member States; and
- explored the health outcomes, needs and challenges.

Exclusion criteria:

- articles with an undefined population or no specific mention of refugees or migrants;
- studies reporting on ID but not specifically closed facilities where deprivation of liberty occurred (instead discussing open or semi-open facilities);
- studies not reporting primary data;
- literature reviews, editorials, commentaries and letters (for peer-reviewed literature); and
- no full-text available.

Peer-reviewed literature was first screened by title and abstract and then for studies using scientific evidence derived from quantitative, qualitative, case study, meta-analysis or mixed method approaches. The identified studies were reviewed for full text independently by two individuals (for the English round). The results were narratively synthesized.

For the grey literature, reports and articles were only included if they met all initial inclusion criteria. Reports were also narratively synthesized.

Screening and data management

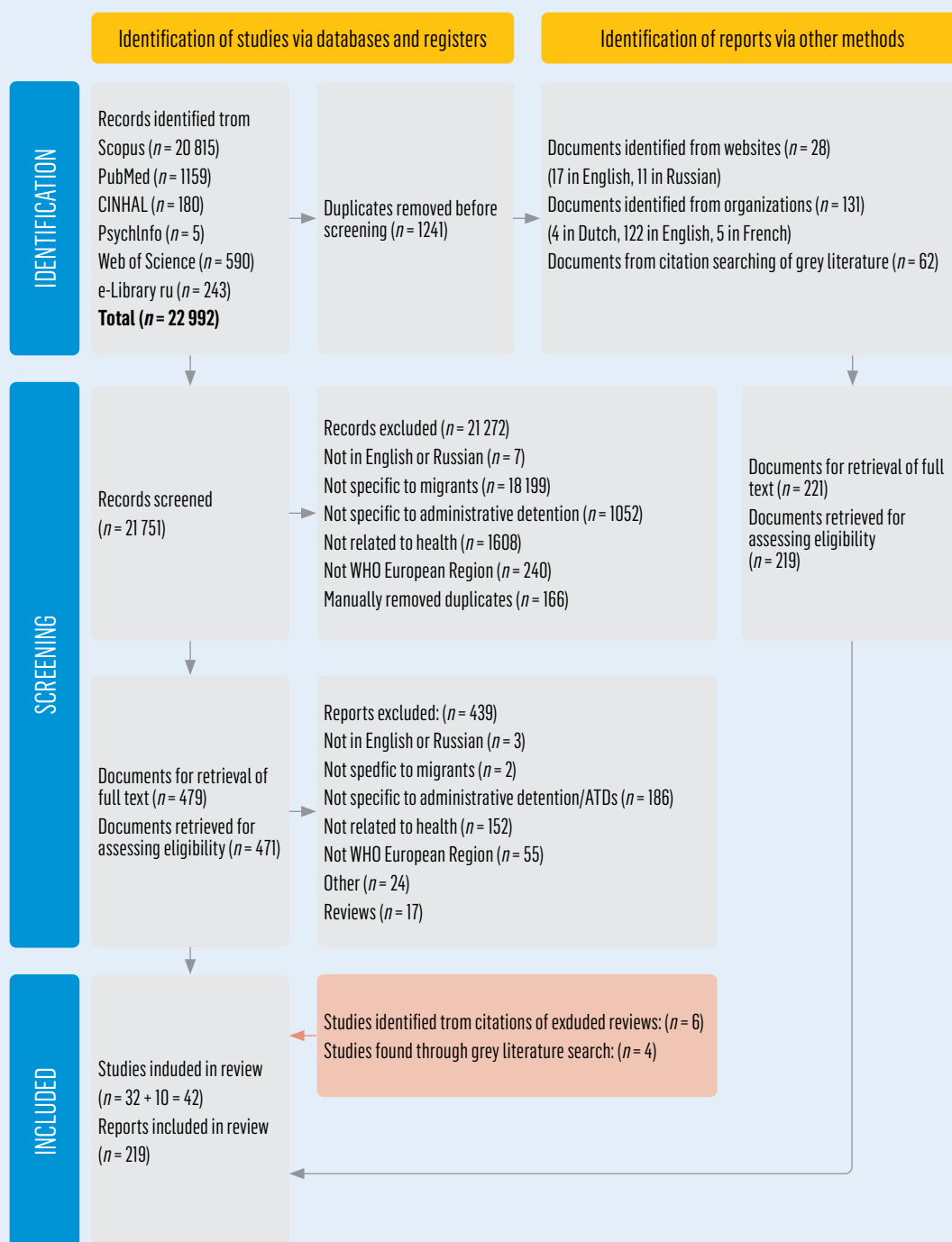
Citation details of all identified documents were collected using reference management software. Group libraries were created and arranged by author's last name; duplicates were removed both automatically and manually. Article selection was conducted by two team members and any uncertainties were discussed during weekly meetings. Literature in Russian was assessed by a Russian-speaking researcher, while articles in Dutch and French were assessed by two of the original reviewers. An Excel file was created to synthesize the main points of all included articles.

After the removal of duplicates from the peer-reviewed literature, 22 992 records were screened during the first round by titles and abstracts; of these 471 were retrieved for full-text assessment. From this, 32 studies fulfilled all eligibility criteria. A further 10 peer-reviewed studies were added from a search of citations in excluded reviews and the grey literature websites. A further group of 219 reports that fulfilled all criteria were included from the grey literature (Fig. A1.1).

The peer-reviewed studies consisted of one meta-analysis, 21 qualitative studies, 19 quantitative studies and one mixed-method approach. For the reports, 115 were country-specific reports

(either reports from monitoring visits or analysis of ID procedures and conditions), which were produced by the Asylum Information Database, CPT, Global Detention Project, the IOM, WGAD and the WHO Regional Office for Europe. The rest of the reports originated from NGOs and other international organizations, as well as a few doctorate dissertations. There were 15 reports that touched on COVID-19 guidance or evidence within ID.

Fig. A1.1. PRISMA flowchart



Data extraction and evidence synthesis

Data extraction was organized by themes and outcomes that were defined during the search strategy.

Primary themes:

- evidence on health impacts of migrants in ID
- evidence on measures to address health challenges in ID.

Secondary themes:

- the environments in ID (physical structures, restrictions and provisions);
- personnel working in ID;
- health provisions in ID;
- challenges in accessing health care in ID; and
- alternatives to detention (impact on health and well-being, overview of availability in the Region).

The 261 included studies and reports were narratively synthesized. For the peer-reviewed studies, the following were extracted into spreadsheets: authors, title, country(ies) of study, year of publication, study type/method, sample size, migrant group, health issues studied, type of ID and main results. The articles were then organized by the main results and health themes in order to identify and synthesize the results presented in the Findings.

A similar process was used for the grey literature with the spreadsheet collecting author/organization, title, language, country(ies), year of publication, migrant group, health issue, type of ID facility and main outcomes. The information from these reports helped to supplement the evidence from the peer-reviewed studies. Most of the grey literature reports were country reports from international and national monitoring bodies. Where possible, bar charts were created to better understand the availability of data on ID in all Member States of the WHO European Region, the environments within ID and information on the management and personnel available in ID.

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health.

The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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