



CARE IN CAPTIVITY?

An analysis of the provision of care for detained asylum seekers experiencing mental health problems

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INTRODUCTION

The Jesuit Refugee Service (JRS) is an international non-governmental organization with a mission to accompany, serve and defend refugees and forcibly displaced people. In Malta, JRS provides information, legal assistance, pastoral care and psychosocial support to migrants and asylum seekers. JRS Malta places a particular emphasis on addressing the needs of those detained in closed centres, precisely because detainees are in many ways invisible and are least able to access services, and make their needs known. Moreover, this focus addresses a current lacuna resulting from the lack of a governmental agency, with a regular presence in detention, providing any form of psychosocial support.

Over the years, close contact with individuals held for months in these detention centres has made JRS acutely aware of the psychological difficulties detainees face, and the myriad adverse mental health consequences they suffer. JRS firmly believes in the paramount importance of a service that effectively responds to the needs of individuals made vulnerable through their mental health problems, in order to safeguard the person's well-being and to ensure that the individual's right to dignified and appropriate health care is guaranteed. To this end, over the past years JRS has offered professional psychological services to migrants in closed centres.

In the course of our work we have witnessed first-hand the efforts made by individuals in the national health service to provide appropriate and dignified care, and tirelessly strive for change in a field fraught with challenges and complexity. However, having also witnessed the acute levels of distress experienced over a long period of time by a considerable number of detainees, we are also concerned about the overall efficacy of mental health services for this population.

We therefore set out to understand the current situation of mental health care provision for detainees in greater depth. This report aims to document the current scenario and analyse 1) if and how the needs of detainees with mental health problems are met, 2) the implementation of vulnerability procedures in relation to these individuals and 3) whether the necessary safeguards are present to ensure that detained individuals with mental health problems are protected from harm and that their well-being is guaranteed. Following an overview of Malta's policies on administrative detention, a discussion of the impact of detention on mental health and the provision of mental health services in Maltese detention centres will be presented. This report will describe the methodology utilised to analyse the data as well as its limitations. It will then go on to present the results and discuss how these could be understood. The report concludes with a number of recommendations for action.



CONTEXT & BACKGROUND

2.1 Malta's Detention Policy

Approximately 15,000 asylum seekers have reached the Maltese islands over the past decade. The majority are unauthorised boat arrivals (90.5% of asylum applicants between 2008 and the first half of 2013 – Office of the Refugee Commissioner, 2013). Maltese immigration law stipulates that every individual who enters, or is present, in Malta without authorization is subject to a removal order that triggers mandatory detention.

Malta's law and policy on detention have recently undergone a radical change, as a result of changes to national immigration law.

Prior to these changes, detention lasted as long as it took for an asylum application to be determined in the case of asylum seekers granted some form of protection, as all granted protection are immediately released from detention. Asylum seekers could remain detained for a maximum of 12 months; those still awaiting a final decision on their application after the lapse of 12 months would be released from detention to await the outcome of their application in the community. Those who did not apply for asylum or whose application was rejected before the lapse of 12 months would remain in detention for 18 months. The only exceptions to these strict rules were so-called "vulnerable" migrants and asylum seekers.

Once an asylum application is finally rejected, the immigration authorities may proceed with repatriation. In practice, the repatriation procedure is fraught with difficulties, not least because many migrants arriving by boat are undocumented and it is not easy to obtain the necessary documentation from their countries of origin to effect forced return. The process is further complicated by the fact that Malta often does not even have diplomatic relations with their countries of origin. In fact very few detainees were in fact deported prior to the lapse of the mandatory 18-month detention period. Most of the boat arrivals deported were North Africans, Nigerian and Ghanaians.

In January 2014 a legal provision was introduced obliging the Principal Immigration Office to conduct a regular *ex officio* review of detention in each individual case at regular intervals not exceeding three months¹. As a result of this provision, between July and October 2014 over 250 detainees were released after their detention was reviewed. Those released had spent varying lengths of time in detention, ranging from 3 to 11 months. They included asylum seekers and migrants whose asylum application had been rejected. The only ones not released from detention, just over 50 persons in total, were those who the immigration authorities believed they had reasonable prospects of repatriating.

It should be noted that during the period on which the report is based, the applicable regime was the mandatory 18 month detention policy.

¹Regulation 11(8) of the Common Standards and Procedures for the Return of Illegally-staying Third Country Nationals, introduced by L.N. 15 of 2014 of January 17, 2014

2.2 Policy on Vulnerability

As highlighted above, the only exception to detention concerns individuals who are deemed to be vulnerable due to age, disability, pregnancy or chronic/serious physical and/or serious mental health problems. According to a national policy document published in January 2005:

“Irregular immigrants who, by virtue of their age and/or physical condition, are considered to be vulnerable are exempt from detention and are accommodated in alternative centres... Administrative procedures are in place to release such irregular immigrants from detention once their identification has been determined and they have been medically screened and cleared.”

(Ministry for Justice and Home Affairs, Ministry for the Family and Social Solidarity, 2005, p.11,12)

In practice, two procedures, implemented by the Agency for the Welfare of Asylum Seekers (AWAS), have been established to determine whether or not a particular detainee would qualify for release on grounds of vulnerability. They are: 1) An age assessment procedure to verify the age of those claiming to be unaccompanied minors 2) An adult’s assessment procedure employing the Adult Resilience Assessment Tool to determine whether an individual falls within the other recognised categories of “vulnerability”, including disability, old age and physical and/or mental health problems. Individuals who clearly appear to be in a vulnerable situation upon arrival are referred to AWAS by the police. Since this is not done through an in-depth assessment but is based on initial impressions, on arrival police identify primarily cases whose vulnerability is clearly visible such as families with minor children and heavily pregnant women. Such cases do not go through the adult’s assessment procedure, but are released after basic medical screening is done.

Briefly, the age assessment procedure appears to involve a preliminary interview by AWAS in cases where an individual makes conflicting statements regarding their age/DOB upon arrival or in one’s preliminary questionnaire (PQ). Subsequently, an interview conducted by a panel of AWAS staff members (Age Assessment Team; AAT) takes place for those that pass the preliminary interview stage as well as for those who declared to be minors upon arrival. This panel will then take a final decision on the individual’s age claim. A care order is then applied for and issued by the Minister for the Family and Social Solidarity, and once this is in place, the minor is released from detention.

In the case of the second procedure, individuals in a particular vulnerable situation can be referred to AWAS by the Detention Service staff, medical staff and NGOs working in detention, using a specifically designed referral form. In each case, an AWAS social worker will proceed to assess the individual by means of an interview, following which a report, recommending release or otherwise, is compiled and discussed with AWAS management who will then take a decision as to whether the said individual should be recommended for release or whether any other action should be taken (e.g. follow-up in detention). Once referred for release, the Principal Immigration Officer (PIO), will take the final decision on whether to authorise the release.

It should be noted that despite their exemption from detention, all vulnerable individuals, even those clearly falling within a “vulnerable” category, are detained upon arrival and only released after a thorough assessment of their situation, obtaining the necessary clearances from competent authorities and the securing of accommodation in the community. This process in its entirety can take several months.

Earlier this year, on the occasion of Freedom Day, the Prime Minister publicly made a commitment to end the detention of children². So far, alternative reception arrangements were implemented for only one boat with minors

on board, out of the four that arrived since April. Even in this case, the reception arrangements adopted were completely *ad hoc* and seemingly unplanned, with minors and families housed in makeshift facilities at the ex-Trade Fair Complex for the 72 hours required to obtain medical clearance.

It is worth noting however that, during the period on which this report is based some unaccompanied minors awaiting age assessment were held in detention pending the outcome of such procedures and released only once a care order was issued.

2.3 Mental Health Problems in Detention Centres

It is well understood that becoming a refugee is a composite experience (Watters, 2007) encompassing numerous losses and hardships that occur across the pre-migration, flight and post-migration periods. The decision to flee in itself brings about the loss of homeland, culture, tradition and a familiar way of life. Individuals seeking refuge may have also been exposed to several traumatic experiences in their country of origin, such as the loss of family or having to live in hiding without the chance to exercise one’s rights. Furthermore, they may have endured traumatic experiences as they fled their country, such as imprisonment, torture and rape. Subsequently, the post-migration environment is itself fraught with a wide array of adversities including stringent asylum policies and detention practices (Silove, Steel, & Watters, 2000; Castro & Murray, 2010).

These prolonged and acutely distressing events, in particular the myriad losses of status, home and culture synonymous with this experience, have been associated with intense demands on the individual’s psychological systems; examples offered include the loss of meaning and hope (Fischman, 2008) and the upheaval of one’s identity (Alcock, 2003). Empirical evidence has highlighted the significant impact of refugee experiences on mental health, uncovering an association between these experiences and feelings of powerlessness (Farias, 1991, as cited in Muecke, 1992), uncertainty, dependency and of being in the minority (Hussain & Bhushan, 2009). In fact, a meta-analysis of 181 surveys investigating the mental health of 81,866 refugees (Steel et al., 2009) found high prevalence rates of PTSD (30.6%) and depression (30.8%) in this population. Moreover, Porter and Haslam’s (2005) meta-analysis uncovered significantly worse mental health outcomes for refugees in comparison to non-refugee groups (e.g. voluntary migrants).

2.4 The Psychological Impact of Detention

A 10-study meta-analysis, specifically investigating the impact of immigration detention on asylum seekers, indicated an association between this practice and poor mental health outcomes, with the presence of high levels of anxiety, depression and PTSD being observed in all studies (Robjant, Hassan, & Katona, 2009).

Detention has been described as a “system that by its very nature causes psychological harm” (Fazel & Silove, 2006, p. 252) and considerable literature has shown that it may have an adverse effect on a refugee’s mental health (e.g. Silove, Steel, & Watters, 2000) either through the stressors it imparts as an institution or by compounding the trauma experienced by individuals prior to arrival.

²<http://www.timesofmalta.com/articles/view/20140331/local/Migrant-children-should-not-be-in-prison-PM.512887>

In a Maltese study relating to the impact of detention on individual’s psychological well-being, 80% of respondents reported that their mental health was affected by being in detention, with 65% indicating that their needs, in particular access to appropriate treatment, was not being met. “According to the detainees interviewed, this deterioration is due to several factors, which include: the fact of being locked up, being separated from the world, worries, mental health problems, living conditions, separation from loved ones and past traumas” (JRS, 2010, p.10).

Internationally, countless studies have highlighted the fact that while in detention, migrants are commonly exposed to an environment characterised by loss of liberty, disconnection to family and the outside world, harsh treatment or abuse from staff, prolonged inactivity and lack of adequate information or knowledge about one’s legal situation (e.g. Fazel & Silove, 2006; Keller et al., 2003).

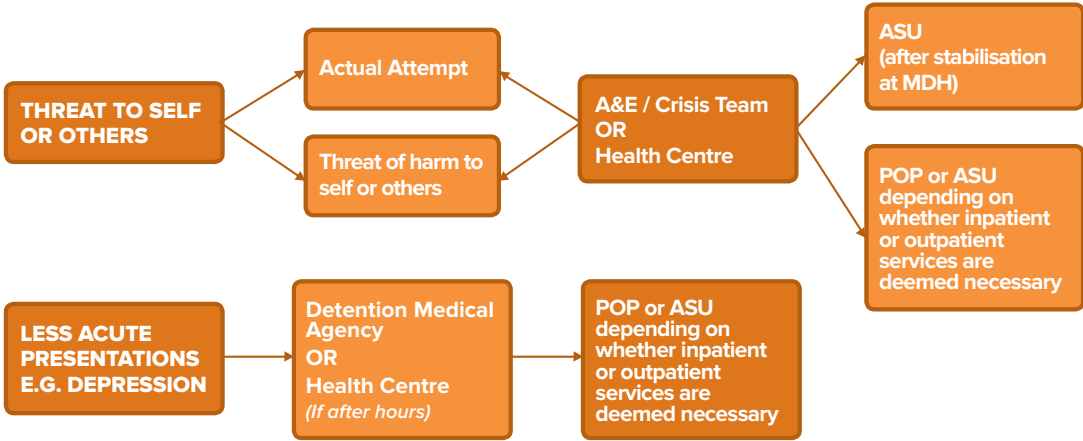
This often results in an atmosphere of mistrust, uncertainty and arbitrariness for the individual, where they may feel degraded, undignified and isolated. Goffman (1961) describes how the environment created by such closed institutions has a tendency to strip an individual of that which allows the maintenance of a healthy sense of self. These would include the loss of choices, status and support structures by exposing him/her to the prolonged cessation of past roles. Furthermore Goffman also notes a loss of individuality, and extreme loss of control over one’s safety, presentation and life path in these institutions. The state that the migrant is hence forced into can have a profound effect on his/her sense of self, triggering the emergence of associated psychological issues.

In this context, the potential adverse impact of detention on the individual can be more effectively understood and one is left with little question as to why observations of detainees have indicated experiences of profound hopelessness, despair and suicidal ideation and why mental health problems such as depression, panic disorder and PTSD are increasingly prevalent (Salinsky & Dell, 2001; Pourgourides, Sashidharan, & Bracken, 1996).

2.5 Mental Health Services in Maltese Detention Centres

At the time of reporting, access to mental health services for refugees and asylum seekers that encounter such difficulties while in detention was obtained through a private medical agency, contracted to provide the services of a General Practitioner (GP) and a nurse in all detention centres on weekday mornings. Individuals wishing to avail themselves of this service must make their need known to detention service staff who would then allow them a visit to the doctor. Once mental health needs are apparent, these individuals would be referred by the GP to the government psychiatric services, either directly or via a national health centre. Recently, the service of a GP in the centres was no longer available and individuals requiring health care were taken to health centres or to Mater Dei Hospital. Government psychiatric services currently consist of inpatient services at Mater Dei Hospital (MDH) and Mount Carmel Hospital (MCH), and outpatient services at the Psychiatric Outpatients (POP) at MDH. In the case of an emergency or the absence of a GP referral, the Crisis Intervention Team operating from MDH’s A&E department would offer immediate support prior to the individual’s referral to inpatient or outpatient services. Should inpatient care be deemed necessary, detained refugees and asylum seekers are generally admitted to MCH and accommodated within a specific ward, Male Ward 8B, also known as the Asylum Seekers Unit (ASU).

Diagram of Existing Referral Pathways based on JRS’ observations



ASU is a medium-secure psychiatric unit that caters for 10 individuals (irregular migrants who are currently being detained) and operates on a “mixed gender” policy (Mental Health Service, 2011). It is hence staffed by male and female nurses together with a police officer for security reasons. Assistance is also provided as required by the medical officer on call (Mental Health Service, MCH, 2011). It is also noted that all patients are assigned a consultant psychiatrist together with a multi-disciplinary team. The ward consists of small, secure rooms with only a bed and a toilet bowl. Each room has a barred window looking onto a corridor and a door opening onto the other corridor which is opened for a few hours a day. The corridors are furnished with a row of benches and a TV unit used by patients when out of their bedroom. At the time of writing, this unit additionally accommodated Maltese female inmates with

substance abuse issues and was therefore also staffed by a prison warden together with detention service personnel. Apart from a shower/toilet room, nurses/doctor’s office, treatment room and store, the ward has no recreational facilities or room for therapy sessions to take place. As these individuals are still detained under Maltese law they are not allowed to leave the ward at any time. Patients have access to Occupational Therapy (OT) services at the discretion of the consultant psychiatrist. At the time of writing, having this service take place within the ward was not always deemed feasible and hence not always offered.

The conditions for migrants receiving inpatient treatment in the ASU were described by the European Committee for the Prevention of Torture (CPT) in their report on their 2008 and 2011 visits to Malta. According to the CPT reports:

“The worst living conditions [of all the places of detention visited] were observed in the Irregular Immigrants’ Ward (IIW). Since the CPT’s last visit, the IIW had been transferred to the former secure facilities of Male Ward 10 (see CPT/Inf (96) 25, paragraph 93). The 10 single cells were still of an antediluvian design. Each measured just under 8m² and contained only a bed (with bedding), bolted to the middle of the floor, and an Asian toilet. The ventilation in the cells was adequate; however, the cells received natural light only through a barred aperture facing onto a long observation corridor. Moreover, the artificial lighting was rather poor. The one patient being accommodated there at the time of the visit was held under these conditions for 23 hours a day (only being allowed to leave his cell for one hour a day for a walk in the corridor). There were no organised activities for patients at the IIW. This state of affairs was exacerbated by the fact that, according to the rules in force, patients could only leave their cell one by one and were therefore held in de facto isolation. To sum up, the living conditions at the IIW can only be described as basic. Furthermore, the Committee has strong reservations about whether it is appropriate to seclude patients on the basis that they fall into a particular category, rather than on the merits of each individual case. As regards treatment and care, it was exclusively based on pharmacotherapy.” (p.57)

“In the Irregular Migrants’ Ward, living conditions were far below any acceptable standard and can only be considered as anti-therapeutic. The design of the ten cells, which was described as antediluvian in the report on the 2008 visit, had not changed at all.” (p.32)

Medicins Sans Frontieres (MSF) also comments about the physical conditions in ASU, and the quality of care there, in their report on medical care provided to detained asylum seekers. This report, published in July 2009, states that:

“Detained patients who require in-patient psychiatric care are admitted to Mount Carmel Psychiatric hospital. All detainee patients are admitted to a special ward which has ten individual cells intended only for detained migrants and asylum seekers and which is permanently guarded by a policeman. The ward is staffed by one nurse per shift from an agency and not by regular hospital staff. The ward is in an unused section of the hospital and the two neighbouring wards are abandoned. It offers no possibilities for social interaction between patients and has no provision for any activities. Patients spend long periods in solitary confinement in their cells.” (p.24)

The lack of adequate interpretation services in Mount Carmel Hospital was also highlighted by MSF in their April 2009 report, which states that:

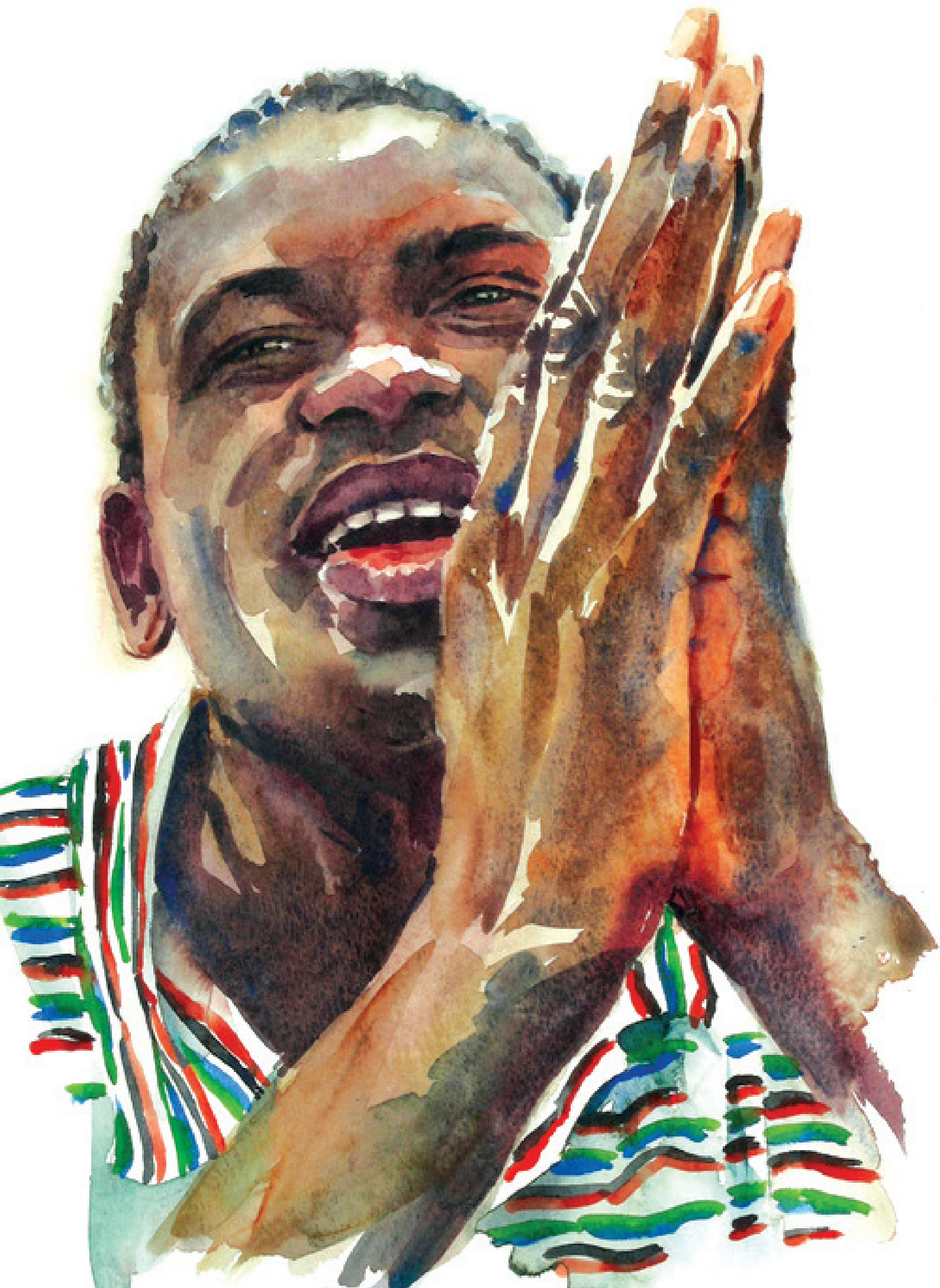
“Translation is not available. As a result, the medical team often has a limited understanding of the patients’ history, symptoms and experience. The patients have little or no understanding of the received treatment – even regarding psychiatric medication with possible severe side effects. Consultant supervision is limited to a weekly visit.” (p.24)

From what we have observed, the physical conditions in ASU mentioned in these extracts have not changed and interpretation services are still largely unavailable. To our knowledge, the changes that have taken place since these reports were published, amount to an increase in staff and the refurbishment of the wards and area outside ASU.

2.6 JRS’ Work and Presence in Closed Centres

JRS’ work in detention consists of: regular outreach visits to provide information, receiving requests for assistance and identification of asylum seekers in need of protection and/or assistance; in-depth casework involving the provision of legal assistance, social work services; and individual and group psychological support. Furthermore, JRS offers “in-depth services such as social work services, psychological support, nursing support and assistance to access medical care, including through the provision of cultural mediation and interpretation services, to persons identified as being in a particularly vulnerable position” (Bridging Borders Report, JRS 2012, p.15).

Given that the needs of individuals with mental health problems are not always met, they are for us a population of concern. To this end, JRS strives to also offer its service to individuals with mental health concerns both in detention and in the community. Together with its work in the main detention centres of Hal Far and Hal Safi, JRS also supports refugees and asylum seekers in ASU as well as the Corradino Correctional Facility (CCF) through in-depth casework. Specifically, the support offered by JRS in ASU is not intended as an adjunct to government services, but as a continuation of the service we offer in detention and hence includes the “identification, referral and support of vulnerable asylum seekers” (JRS, 2012, p.16). Such support is provided by the JRS psychosocial team and includes, as mentioned above, psychological therapy, social work services, pastoral care and other forms of support. Due to the observed problem of poor follow-up in closed centres, as well as in the community, regular follow-up of those individuals referred as vulnerable takes place through our weekly presence in detention centres and specific visits to MCH.



METHODOLOGY

In order to meet the aims of this report, data was gathered through the records and observations made during JRS' weekly outreach work in closed centres, as well as working notes and reports developed following in-depth casework. For ethical reasons, no identifiable client information will be presented and all data will be presented as collective statistics.

The data compiled spanned a 6-month period from 1st December 2013 to 30th June 2014. The data available was reviewed, to determine which data was useable and would shed most light on the mental health treatment of refugees and asylum seekers in Malta. This led to the development of the following categories: basic demographics, psychological presentation, language proficiency, legal status, vulnerability assessment, attendance of hospital appointments, and referral and access to psychological services. The extracted data specifically related to, and only included, clients that were under inpatient psychiatric care (at the ASU ward) at some point during their detention period (from now on referred to as "population of interest"). A total of 74 clients met these criteria and hence data analysed pertains to these individuals. Once compiled, data was analysed and basic statistics were drawn up for each category, the results of which are presented in the following section.

While data was compiled and analysed rigorously it must be noted that the methodology used is not devoid of limitations. Firstly, because of the nature of the data collection procedure, the data gathered includes

those individuals encountered through our work and not the total population of interest. Having said that, JRS' regular presence in detention centres together with the employment of trained interpreters allows the organisation to have contact with most detainees and communicate effectively with the vast majority of them. Therefore given that, in all probability, the majority of detainees requiring inpatient treatment in a given 6-month period would have come in contact with JRS, the sample of 74 patients included in this report may be considered a fair representation of the population of interest. Secondly, a number of the variables under investigation were obtained through client self-report and hence associated limitations must be taken into consideration; for example, the inaccuracy of the presentations described in the report, as these were derived from self-reported symptoms and not objective, professional judgements. Lastly, while analysed data pointed to the existence of certain barriers to effective care, these were not comprehensively covered by our data collection methods, leaving us unable to quantify and understand the extent of occurrence of these barriers.

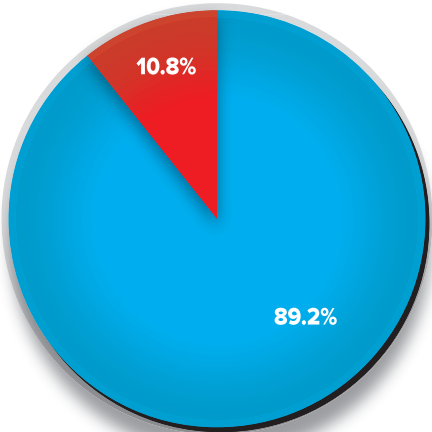


RESULTS

4.1 Demographics

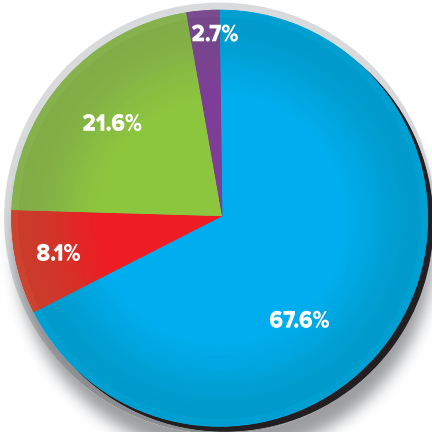
4.1.1 Gender

Of the 74 individuals sampled, 66 were male, while 8 were female



- Male
- Female

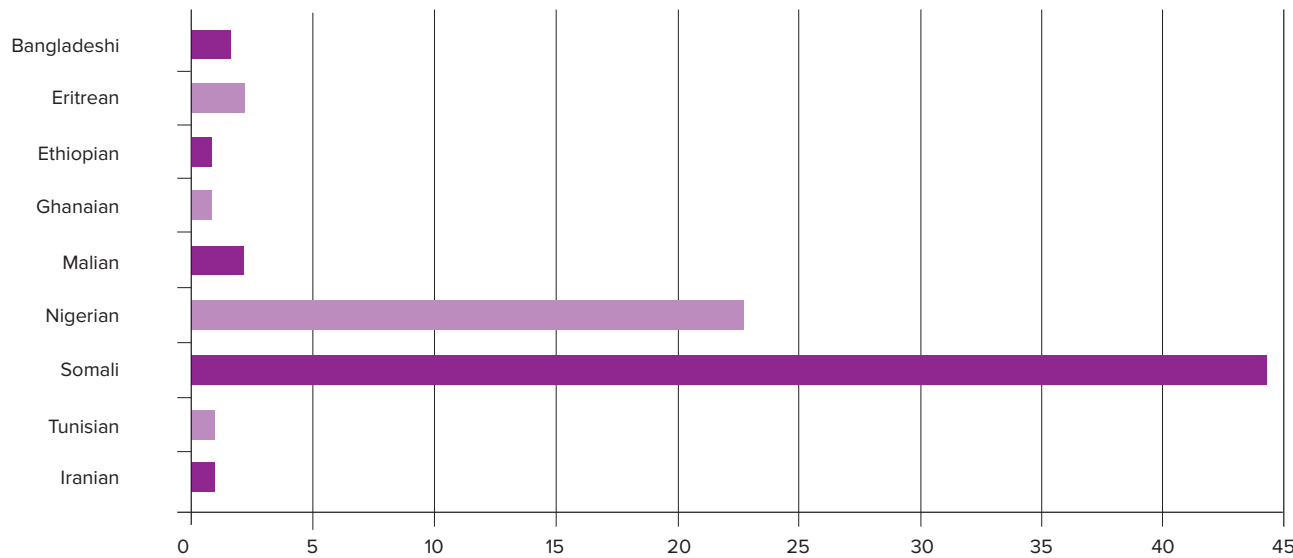
4.1.2 Age



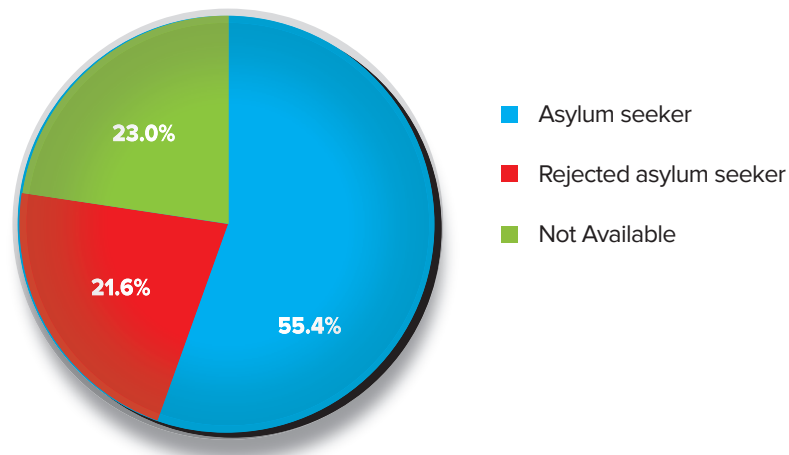
- Adult
- Claimed Minor
- Claimed Minor-Declared Adult
- Confirmed Minor

50 of the individuals were identified as adults, 6 claimed to be minors, 16 claimed to be minors but were declared adults following an age assessment interview and 2 individuals were confirmed minors

4.1.3 Nationality



4.1.4 Legal Status on Admission



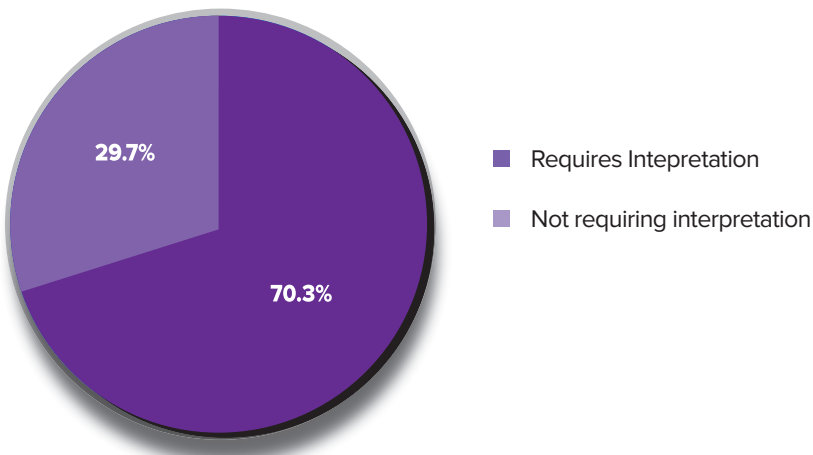
Results indicate that 41 individuals were asylum seekers and hence could still become beneficiaries of protection. Of these, 13 individuals were awaiting a decision at first instance, and 28 had their claims rejected at the first instance, had appealed and were awaiting a reply. The remaining individuals for whom this data was available were ones whose applications had been rejected, meaning they were not granted protection in Malta. Since ASU is the psychiatric inpatient facility for individuals still detained, none of our population of interest had at that point been granted protection, as once protection is granted individuals would be transferred to other wards in Mount Carmel Hospital.

4.2 Communication

The following chart shows the percentage of individuals requiring interpretation in order for them to communicate effectively with the mental health service provider and those that were proficient enough in English to be understood and to understand the exchanges taking place in relation to their mental health.

Subsequently, chart 4.2.2 depicts the kind of access to interpreters the former had by using the following categories: availed of the services provided by JRS cultural mediators³⁴, was provided with an untrained interpreter, instances of using both a JRS cultural mediator and an untrained person and no access at all. In this regard, it is relevant to note that, based on the premise that the barriers to effective communication in this field are more than just linguistic, JRS offers the service of cultural mediation (CM). The cultural mediators employed by JRS would have all been trained prior to, or during, the course of their employment. In this chart, “untrained interpreters” refers to fellow detainees, patients or staff e.g. nurses not specifically trained as cultural mediators that were observed or reportedly acted as interpreters for certain exchanges of the individuals and their service providers.

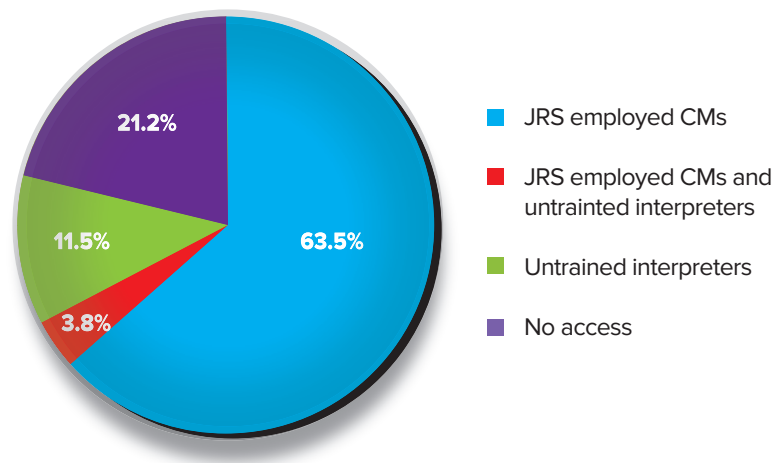
4.2.1 Need for Interpretation



³Cultural mediators help service providers to understand and be aware of cultural practices which might have a bearing on the way users approach the service. They are also a resource to inform clients/patients of their entitlements and the way the system works and how it should be accessed. In addition, they play an important role in empowering clients/patients, by informing them and encouraging them to voice their needs and concerns (Martin & Phelan, 2010).

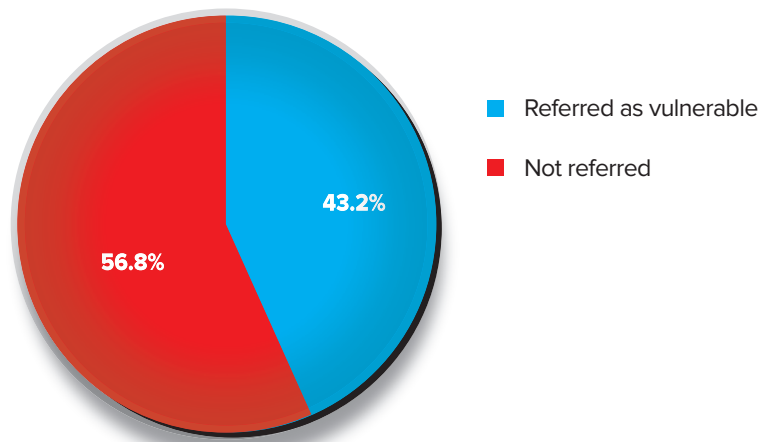
⁴It is relevant to note that this does not mean that 63.5% of the sample benefitted from the services of a JRS cultural mediator for all their appointments.

4.2.2 Access to Trained Interpreters/Cultural Mediators



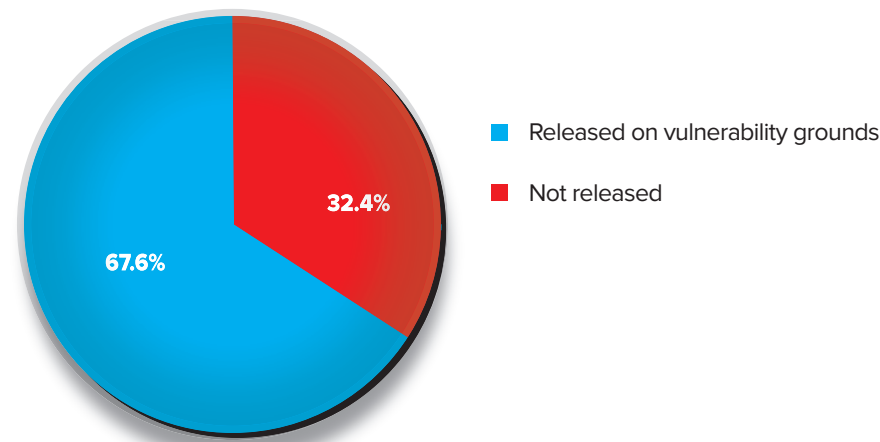
4.3 Vulnerability Assessment

4.3.1 Referred for Vulnerability



This chart indicates that 32 of the individuals (43.2%) in this report were referred by JRS to the Agency for the Welfare of Asylum Seekers (AWAS) for early release on grounds of vulnerability. Moreover, a certificate explaining the reason for their vulnerability was provided by a mental health professional for 31 of these individuals.

4.3.2 Release on Grounds of Vulnerability

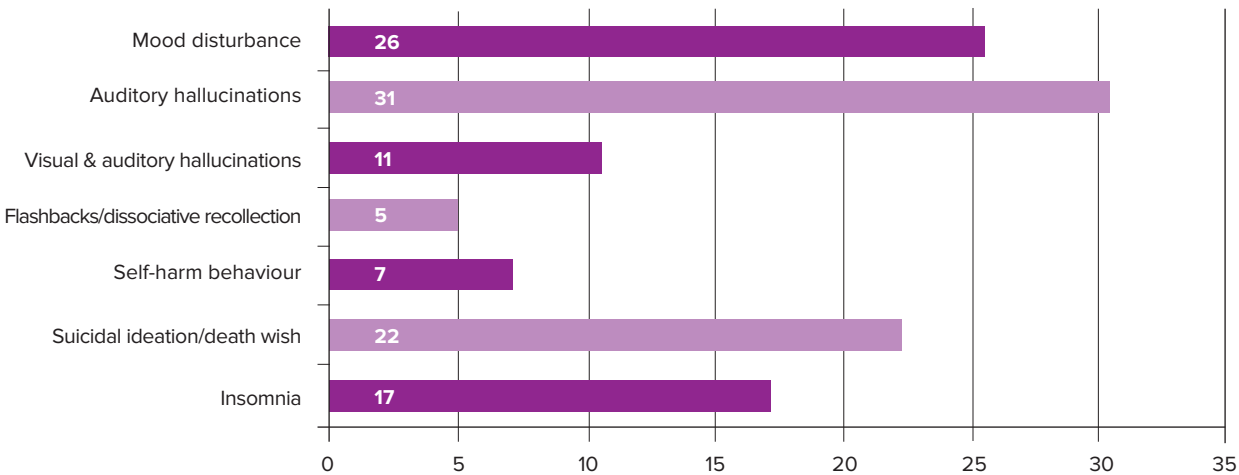


Out of the total sample, 24 (32.4%) were released from the closed centres on mental health vulnerability grounds. Data analysis indicated that 75% of those referred on grounds of vulnerability were released, with the remaining 8 cases being released on other grounds before a decision was taken (e.g. receiving protection). Data available through our in-depth casework also indicated that the average time lapse between referral of an individual and their release on vulnerability was 9.1 weeks.

4.4 Symptomatology

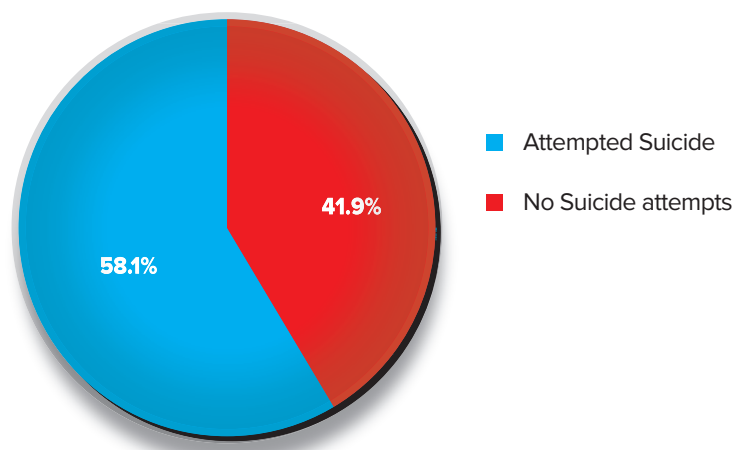
Data relating to the individuals’ mental health presentation while in ASU was available for 77% of the individuals (i.e. 57 individuals). This data, obtained through self-report is depicted by symptom breakdown in the following graph.

4.4.1 Reported Mental Health Symptoms



4.4.2 Suicide Attempts

Throughout the data compilation process it became apparent that an overwhelming number of individuals had attempted suicide while in the detention centre and hence a specific statistic was drawn up to describe this. As depicted in the chart below, 31 individuals (41.9%) had attempted suicide prior to being admitted. Of these, 3 individuals also attempted suicide repeatedly while in ASU.

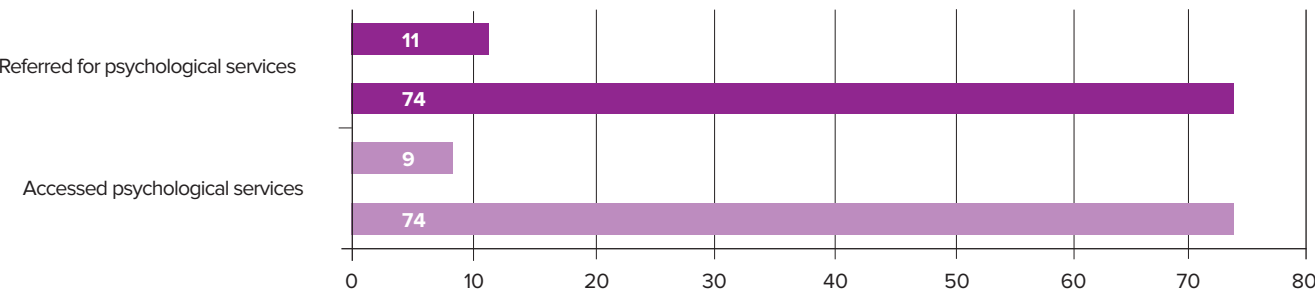


4.5 Accessing Mental Health Services

4.5.1 Attendance of Hospital Appointments

While hospitalised at ASU, all individuals had access to psychiatrists and nursing staff on a regular basis. However, once a patient was sent on leave and accommodated at the detention centre once again, they were dependent on detention staff to keep a record of and to attend their appointment at MCH. Our data indicated that out of the 74, 6 individuals claim to have missed one or more hospital appointments/psychiatric reviews as they were not taken out of the closed centre to the hospital.

4.5.2 Referral and Access to Psychological Services



Data indicates that from the 74 individuals covered by this report, 11 were referred to psychological services by the psychiatric teams treating them, with 9 of these individuals receiving psychological therapy. The latter was most often provided by JRS.

4.6 Closed Centre Duration and Frequency of Admission

Data analysis indicated that the individuals in this report spent an average of 10.1 months in detention centres and their average inpatient stay in ASU was 3.9 weeks. Some patients were admitted repeatedly with an average of 1.7 admissions per person. The following tables depict the ranges on which these averages were based.

LENGTH OF TIME IN DETENTION	NO. OF CASES	PERCENTAGE
0-6 months	6	10.7
7-9 months	10	17.9
10-12 months	31	55.4
13-16 months	9	16.1

AVERAGE INPATIENT STAY IN ASU	NO. OF CASES	PERCENTAGE
1-2 weeks	27	38.0
3-6 weeks	31	43.7
7-10 weeks	11	15.5
11 weeks +	2	2.8

AVERAGE NO. OF ADMISSIONS	NO. OF CASES	PERCENTAGE
1 admission	38	53.5
2 admissions	21	29.6
3 admissions	9	12.7
4+ admissions	3	4.2



DISCUSSION

5.1 Introduction

This chapter aims to explore what the results can tell us about how the needs of detainees with mental health problems are currently being met and evaluate the extent to which these vulnerable individuals receive the care and protection they need.

5.2 Number of Inpatients

The data collected indicates that, over a six month period, 74 detainees received inpatient treatment at the ASU ward with an average stay of 4 weeks. This is certainly not an insignificant amount in a ward that has the space to cater for 10 detainees; furthermore data also indicates that at a fixed point in time over these six months, a maximum of 24 detainees⁵ were hospitalised at the ASU ward. In light of this, a pertinent question that must be asked is whether the ward in question is equipped to deal with the amount of detained asylum seekers that require inpatient treatment. Data seems to be indicating that over the 6 month period in question the ward needed to cater for amounts of patients that are well beyond its capacity. Analysis of statistics detailing asylum trends in Malta over the past 10 years indicates that the total amount of boat arrivals per year fluctuates to a considerable degree, with a minimum of 47 arrivals in 2010 and a maximum of 2,775 arrivals in 2008 and an average of 1,647 arrivals per year (UNHCR⁶). Such a fluctuation is obviously due to the combined impact of myriad factors, many of which are difficult to predict. While the total amount of asylum seekers arriving in Malta this year has been comparatively low so far⁷, it is conceivable that it might increase again in future years due to changes in the political and security situation in countries of origin and transit. Having said that, even if the number of arrivals remains comparatively low the current detention policy which is characterised by increased uncertainty, with all but few being released after a few months, could lead to an increase in the number of detainees requiring treatment.

Given that past experience has shown that the population of our detention centres can easily amount to a thousand individuals at any given time and the fact that asylum seekers are a population at high risk of mental health problems, being able to cater for only 10 patients may limit the efficacy of the service provided. It might also limit detainees' access to psychiatric services, as staff might be inclined to keep inpatient stays to the minimum possible duration so as to avoid overcrowding in the ward.

⁵ This number does not include those detainees that were sent "on leave"

⁶ Retrieved from <https://drive.google.com/folderview?id=0B6aJpCO6sQYhTDJlb0NPdWNHakU&usp=sharing>

⁷ 568 arrivals by the end of September 2014

5.3 Duration of Hospitalisation and Frequency of Admission

Results indicate that the majority of the sample were hospitalised for a prolonged duration, with 62% spending more than 3 weeks and 13 individuals spending more than 7 weeks as an inpatient accommodated at ASU. The average duration suggests that most hospitalised detainees required substantial input from hospital staff and services, again indicating the high level of demand placed on the limited capacity of the ward in question.

Data collected indicates that re-admission was a common phenomenon with 30% of the cases analysed being admitted twice and 17% being re-admitted three times or more. The data available unfortunately does not shed light on the reasons behind these multiple admissions. Hypothetically a high rate of re-admission could be considered indicative of a high rate of relapse, which would be theoretically plausible given patients are taken back to a custodial environment with poor living conditions. Still, such a hypothesis would need to be verified by a more comprehensive investigation.

Data highlights the fact that the number of inpatients, together with the average duration of hospitalisation, places a substantial demand on the ASU ward which it is ill-equipped to deal with. Further to this, the data collection sources employed have highlighted the less than favourable conditions of this ward, including the over-emphasis on security, the lack of amenities and activities for patients, poor hygiene and lighting, and the highly clinical and sterile physical appearance of the bedrooms and common areas. Patient self-report also repeatedly highlighted the perception that the living conditions in ASU were no better, or sometimes worse, than those in detention, and that these conditions acted as a significant stressor during their inpatient stay. Among others, they reported the lack of opportunity for socialising, the deprivation of movement being locked up in small rooms for most of the day, and the degradation of dignity (for example, through their toilet being in their room, when this is possibly shared by more than one person, and the request for the toilet to be flushed by ward staff from the outside). It can hence be argued that an inpatient service that is in essence supposed to provide patients with an opportunity to deal with their mental health problems on the road to recovery, offers an environment that is as, or even less, therapeutic than that in the detention centres, leading one to question the potential for real treatment and recovery of detained asylum seekers with mental health problems.

5.4 Demographic Composition

An initial analysis of the results consisted in comparing and contrasting the demographic compositions of the study’s sample, and the boat arrival population in 2013 (UNHCR⁸), to check whether any demographic group in the detention population is particularly at risk of MH problems. The gender composition of both groups indicated no significant discrepancy, with males constituting the vast majority in both cases (i.e. psychiatric inpatient sample - 89%, boat arrival population - 84%). In terms of nationality, more than half of the inpatient sample was Somali (60%), which roughly corresponds to the composition of arrivals in 2013 when Somali migrants comprised 50% of the total population. On the other hand, it is interesting to note that Eritreans, who were by far the second largest group of arrivals (23%), were relatively under-represented at 2% (i.e. only two cases), whilst Nigerians who comprised 4% of all arrivals were over-represented at 24%. In terms of age 32% of the study’s sample claimed to be minors, which again is not very different from the 25% of all arrivals in 2013.

⁸ Retrieved from <https://drive.google.com/folderview?id=0B6aJpCO6sQYhTDJlb0NPdWNHakU&usp=sharing>

As an added analysis, the distribution of nationalities per legal status categories was calculated:

NATIONALITY	LEGAL STATUS					
	Asylum Seeker		Asylum Seeker (1st reject)		Rejected Asylum Seeker	
	(%)	No. of cases	(%)	No. of cases	(%)	No. of cases
Bangladeshi	0%	0	4%	1	0%	0
Ethiopian	0%	0	4%	1	0%	0
Eritrean	15%	2	0%	0	0%	0
Ghanaian	0%	0	0%	0	6%	1
Iranian	8%	1	0%	0	0%	0
Malian	0%	0	11%	3	0%	0
Nigerian	23%	3	18%	5	25%	4
Somali	54%	7	64%	18	69%	11
Total	100%	13	100%	28	100%	16

Results show that the distribution of nationalities is relatively stable across legal status categories, indicating that Nigerians are relatively over-represented across all categories. This trend may be interpreted as indicating that the reasons why a relatively high number of Nigerians necessitate inpatient treatment are probably more associated with cultural background, or commonality of experiences in country of origin and during transit, than failure to secure protection or the risk of deportation

This analysis appears to indicate that, with the possible exception of nationality, there are no particularly distinguishing demographic characteristics in the psychiatric inpatient population. This therefore seems to indicate that, broadly speaking, the detainees receiving inpatient psychiatric treatment are from a demographic perspective representative of the general detention population. A hypothesis that is sometimes voiced among people working or involved in the migration field is that the majority of detainees accessing inpatient psychiatric care are doing so in order to avoid deportation. In this regards, it is relevant to point out that, as to date regular deportation occurs only to Ghana and Nigeria, only 26% of the inpatient sample were conceivably at risk of deportation and that 3 out of the 74 cases were eventually deported.

5.5 Legal Status on Admission

Before discussing the patients’ legal status on admission, it is necessary to clarify a fundamental premise: Given that we are speaking about inpatients in a psychiatric ward utilised for immigration detainees, patients can either be individuals who are still going through the asylum determination process, rejected asylum seekers or persons who did not apply for asylum. This means that comparing the rates of protection between the study’s sample and the general asylum seeker population would be of limited relevance, as only individuals without any form of protection would be treated at the ASU ward. In this regard, research that takes into account all refugees and asylum seekers accessing psychiatric services, and explores whether there are significant differences in the proportion of recipients of international protection between this population and the general refugee and asylum seeker population, would be more enlightening.

Results indicate that a sizeable majority of the study’s sample were asylum seekers (72%), with only the minority being rejected asylum seekers (28%). On the other hand, a significant proportion of these asylum seekers had their asylum applications rejected at first instance, and were at appeal stage, with only 23% still awaiting the Refugee Commissioner’s decision. In practice, the majority of asylum seekers with a first reject are also rejected at the appeal stage and this is a well-known fact among detainees. It can therefore be argued that most detainees would perceive a first reject as them being rejected asylum seekers. In line with such an argument, it appears that failure or perceived failure to obtain protection could act as a precipitating factor for individuals that are vulnerable to MH problems.

On the one hand, this data might be interpreted as confirming an often voiced suspicion regarding detainees malingering about their symptoms with the aim of obtaining release from detention on vulnerability grounds, once protection is not granted. On the other hand, being denied protection can be viewed as a legitimate trigger leading to the development of MH problems that require professional treatment. Given the factors mentioned in the Introduction (i.e. detention’s detrimental impact on mental health, and the risk of psychological problems in an asylum seeker population), the stress of the asylum determination process, and the huge personal investment asylum seekers place on securing protection, it is perfectly understandable that a failure to receive protection is going to have a very real detrimental impact on the individual’s mental health condition. Although in certain cases malingering may occur and this might put added pressure on available mental health services, a reception system that is less of a hazard to the asylum seekers’ mental health would most probably translate into less need for treatment and therefore less demands placed on current resources.

5.6 Symptomatology

5.6.1 Mental Health Status

Although self-reported symptoms are far from conclusive in determining the prevalence of mental health disorders, in this case they can help provide a rough picture of the mental health status of detainees requiring inpatient psychiatric care.

As outlined in the Introduction, research investigating refugees’ mental health has consistently found high rates of depression and PTSD in this population. The data collected seems to only partially confirm this trend in the inpatient sample analysed. The fact that 46% of the study’s sample reported mood disturbance symptoms such as low mood, lethargy and emotional lability, can be interpreted as indicating that a substantial proportion were suffering from depressive disorders. On the other hand, the symptoms reported do not shed much light on the prevalence of PTSD in detainees under inpatient care. Flashbacks were the only symptom strongly indicative of the presence of PTSD mentioned and were reported by only 9% of the sample.

However, it is interesting to note that more than half of the inpatient sample (54%) reported experiencing hallucinations (either visual, auditory or both). Whilst, such symptoms are usually considered indicative of psychotic disorders, in certain cases they might also be part of the complex clinical picture of PTSD (Hamner, 2011). Case notes taken indicate that several patients claimed that the content of their hallucinations was directly related to the traumatic events they experienced and that they had no experience of such symptoms prior to traumatic exposure. Hence in the population of interest such hallucinations may be interpreted as being indicative of a psychotic disorder, of the comorbid presence of PTSD and psychotic illness or, although it’s utility as an independent diagnosis is hotly debated, of PTSD with psychotic features.

Whatever the precise diagnosis, at face value it appears that a high proportion of the inpatient sample are experiencing hallucinatory symptoms. Recent research, though, has evidenced that high rates of psychotic disorders/ psychotic symptoms in a refugee population is a common trend. A study conducted in Malta by Camilleri, Grech and Taylor-East (2010) found that among irregular immigrants the incidence of patients with psychosis requiring hospitalisation was 400 per 100,000 compared to 26 per 100,000 in the general population. Kroll, Yusuf and Fujiwara’s (2010) research found that 80% of the Somali male patients seen in a community clinic in Minnesota, USA presented with psychoses⁹, compared to 13.7% of the non-Somali control group of same aged males. Finally, Crager, Chu, Link and Rasmussen (2013) in a study on U.S. migrants found that refugees are at higher risk of psychotic symptoms even when compared to voluntary migrants of the same ethnic background.

This rough clinical picture can only give us a glimpse into the condition and needs of detainees who are admitted to the ASU ward. The symptomatology reported seems to point towards the presence of depressive disorders and of PTSD and/or psychotic disorders, and such a clinical picture would be congruent with what previous research has evidenced in similar populations. In this regard, a study investigating the prevalence of mental health disorders in a Maltese clinical refugee population, and examining the frequency of depression, PTSD and psychotic disorders would be useful in helping to clarify what these needs are and how much they differ from the general inpatient population.

⁹For statistical analysis purposes in this study, all patients with schizophrenia, mania, drug-induced psychosis, and psychosis not otherwise specified were classified in a single category as Psychoses.

5.6.2 Risk of Harm to Self

Data indicates that among the detainees admitted for inpatient psychiatric care there was a high risk of harm to self; 12% of the sample engaged in self-harm behaviour, 39% expressed suicidal ideation or death wish and 42% attempted suicide. Most of these suicide attempts occurred during the individual’s stay in detention and would have constituted the principal reason for their admission to the ASU ward. This seems to indicate that a significant proportion of detainees with mental health difficulties only start accessing treatment after attempting suicide, possibly after their mental health has already suffered from considerable deterioration.

There are several plausible explanations for why detained migrants do not access treatment before their mental health condition reaches a crucial stage. Among the majority of detainees there is a general lack of awareness about MH problems and how they manifest themselves, with symptoms such as auditory hallucinations or insomnia being viewed as mysterious, odd and/or embarrassing. This lack of awareness is compounded by the mental health stigma prevalent among detainees that is itself a product of the negative perceptions of mental illness common in many of the cultural contexts detainees hail from. For example, Ukbong and Abasiubong’s study (2010) assessing attitudes in Nigeria revealed the presence of strong negative views about mental health problems with more than half of respondents expressing beliefs about supernatural causation. Literature suggests that in Somali culture there conceptually is no spectrum of mental health or illness – one is either “crazy” or not “crazy” – and that the resultant stigma surrounding mental health issues prevents many Somalis from seeking help (Schuchman & McDonald, 2004). Finally the data sources analysed also revealed instances of detainees reporting not being referred to psychiatric services by health care providers in detention despite repeated complaints about their mental health difficulties. Hypothetically this alleged failure to refer may be due to suspicion of detainees malingering so as to be released on vulnerability grounds. If verified, this would constitute another added barrier to detainees with mental health problems accessing appropriate services. Moreover it needs to be added that the current unavailability of a GP service probably means that, as compared to the time period covered by this report, accessibility to mental health services has diminished further.

In conclusion, data regarding the sample’s symptomatology appears to indicate that a substantial proportion of detained asylum seekers being admitted to the ASU ward necessitate long-term psychiatric and possibly psychological treatment on an urgent basis.

5.7 Need for and Availability of Interpreters/Cultural Mediators

The fact that 70% of the sample claimed to have no or very limited language proficiency in English, and reported the need of an interpreter highlights a current deficiency in the mental health services provided to detained migrants. Currently, no trained interpreters are employed by either the health care providers in detention centres or by governmental psychiatric services, meaning the majority of detainees with mental health difficulties struggle to make themselves understood. Literature indicates that in mental health settings a good understanding of what the client is reporting is crucial to providing an effective service. For example, Bloom et al. (2005) claim that professionals who cannot communicate effectively run the risk of making an incorrect diagnosis, having their advice ignored, or failing to develop appropriate solutions. Empirical research has provided evidence confirming that inadequate communication between clinician and client leads to an increase in probability of diagnostic and treatment errors (Minas, 1991). Furthermore, it is relevant to point out that the potential negative consequences of this heightened risk of diagnostic and treatment error can be especially severe in a population with a high risk of harm to self.

Currently the provision of trained cultural mediators to cater for the needs of inpatients at the ASU ward is dependent on an external provider (i.e. JRS) who is offering the service free of charge. We believe that such a state of affairs, where a crucial service depends on an NGO reliant on short-term and project-based funding sources, is far from ideal both from a sustainability and service development perspective.

It is also important to point out that during the data collection period, three separate cases were reported where either other migrants from the detention centres, or fellow inpatients, were entrusted with the responsibility of interpreting for the patient. While we can’t be sure of the extent of this practice, any indication that such makeshift solutions are pursued is worrying for a number of reasons. The use of fellow detainees as interpreters may be problematic because of confidentiality issues and the high levels of stigmatisation of mental health difficulties among immigrant communities in Malta. A detainee being labelled as “crazy” could face countless myriad adverse consequences both in detention, and later in the community, including ostracisation, bullying, and being considered unfit as an intimate partner. Furthermore interpreting is a highly skilled service that goes beyond basic knowledge of two languages and the dangers of miscommunication in such a setting, where the diagnosis and treatment of the patient is heavily dependent on self-reporting, are very high. In fact among experts in the field of cross-cultural health care there is consensus that the use of untrained interpreters poses risks to the patient, the provider, and to the individual interpreting (Bowen, 2001). A report by the US Office of Minority Health (1999) noted that, due to the false sense of security provided to both the provider and patient that accurate communication is taking place, utilising untrained interpreters (including family and friends) may be even more dangerous than employing no interpreter at all.

5.8 Access to Psychological Therapy

According to our data, only 11 individuals out of the total sample were referred for psychological therapy. The relatively low number of referrals for psychotherapy seems to confirm the emphasis on pharmacology in the treatment and care of detained asylum seekers outlined by the CPT report. It would be useful to investigate whether such an emphasis is particular to the care provided to this particular population, and what are the factors hindering the provision of psychotherapeutic services. Out of the 11 individuals referred, 8 were provided psychotherapy by JRS, 1 was seen by a psychologist employed at MCH, while 2 did not receive psychotherapy. The latter explained that they were unable to enjoy the benefits of such a service because they were not escorted to MCH from the detention centre for their therapy appointments We believe that the same reasoning regarding the provision of interpreting services applies to the provision of psychotherapeutic services; such a crucial aspect of the treatment offered cannot depend heavily on an external source operating on limited means and a short-term project system.

5.9 Implementation of Vulnerability Procedures

As explained in the Introduction, governmental policy states that vulnerable asylum-seekers are to be released from detention to await the outcome of their asylum application in the community, and such vulnerability is ascertained through an individual assessment procedure conducted by AWAS. Technically any agency or individual can refer a detainee to AWAS for early release on vulnerability grounds, but in practice JRS refers the majority of cases due to its regular and professional presence in detention centres and the ASU ward.

Within JRS, the decision about which detainees fulfil the criteria for mental health vulnerability is left to the competence of professional psychologists who base their evaluation on three one-to-one assessment sessions. In this regard, admission to MCH is not considered sufficient as a sole indicator, and while the psychiatrist’s professional judgement plays an important part in the decision-making process, emphasis is placed on submitting each case through the same standardised assessment

A sizeable proportion of the sample (43%) were referred to AWAS for a vulnerability assessment, with the vast majority having been provided a certificate by a mental health professional¹⁰. 75% of these cases were released on vulnerability, with the other 25% being released on other grounds before a decision on their referral was taken. It is significant to note that the average time-lapse between referral and release on vulnerability was 9.1 weeks, and that for 5 cases it took more than 12 weeks from when they were referred for them to be accepted and released. We are of the opinion that these timeframes are to be considered too long for a vulnerability assessment, as a significant deterioration in mental health can occur in such a time period. Given that the rationale behind granting early release in such cases is to safeguard the detainee’s mental health, the amount of time taken for the procedures to be implemented means that this aim is not being met effectively. In this sense it is particularly indicative that a quarter of those referred were released on other grounds before the process was complete.

Additionally it is also relevant to note that patients released on vulnerability had spent an average of 8.9 months in detention and that 9 out of the 24 individuals released on vulnerability grounds were hospitalised for more than 5 weeks. Again this evidence raises questions about whether the current system for implementing governmental policy regarding vulnerability is capable of identifying, assessing and corroborating cases of detainees suffering from mental health problems within appropriate timeframes.

¹⁰ Mental health professional being either a psychologist employed at JRS or a MCH psychiatrist.

5.10 Continuity of Care

The fact that 6 individuals out of the total sample reported failure to be escorted to MCH for a number of their review appointments while “on leave” (along with the previously mentioned reports regarding missed psychotherapy appointments), points towards difficulties in ensuring continuity of care once patients are back in detention. Furthermore, some detainees also reported instances where prescribed psychotropic medication was not dispensed to them in detention. In this regard, the current system where, after discharge from the ASU ward, the responsibility for continuity of care, in terms of attendance of hospital appointments and dispensation of medication, falls under detention health care providers and custodial staff appears not to be operating effectively. While discontinuation of care is, for obvious reasons, always a worrying sign, it is especially so in a context where individuals who are undergoing some form of treatment are placed in an environment that is hazardous to mental health and antithetical to recovery.

5.11 Conclusion

Results highlight the acute needs of detained asylum seekers admitted to ASU and point towards the presence of lacunae in the way these needs are met. Firstly, the physical conditions in ASU, including layout, design and amenities do not foster a therapeutic environment for neither patients nor staff. Other lacunae include the risk of overcrowding in the ASU ward, irregular availability of interpreters, the dangerous use of untrained interpreters, problems in ensuring continuation of care when being released “on leave” or following discharge, and the questionable efficacy of vulnerability procedures. Do we have an effective system in place to offer appropriate safeguards and treatment to a population at a high risk of mental health problems places in closed detention centres? In our opinion, the current scenario is far from ideal, but we believe that a number of implementable solutions would go a long way in improving the current state of affairs. Furthermore, it must be said that this report, given its limitations, can only provide a preliminary sketch of the issues at stake, and raise questions which would require a more in-depth analysis undertaken with the involvement of the relevant service providers to be answered.



RECOMMENDATIONS

6.1 Mental Health Service Provision

1. In order to counter the current fragmentation in the mental health services provided to detainees and associated difficulties in continuity of care, we recommend that the provision of health care services in detention centres is incorporated within the state primary health care system. One way to achieve this would be to entrust the closest health centres with the responsibility of operating an outreach clinic providing the services of a doctor, nurse and social worker on a regular basis, as well as more specialised staff on a less frequent basis. In this way detainees would be accessing mainstream health services directly, and the accountability, management and follow-up of the health services provided would fall under the same body. This would facilitate the attendance of follow-up appointments, regular updating of patients' mental health records, and the provision of prescribed medication. In our opinion, high priority should be placed on the latter, ensuring that all medication is administered to detainees following their discharge from inpatient services in a regular and consistent manner according to their specific prescription.
2. Should this be unfeasible, at the very least, the services of a mental health care professional should be made available within closed detention centres, at minimum, on a weekly basis.
3. In order to ascertain that this population is provided with services in accordance with the Mental Health Act, it is recommended that the Mental Health Commissioner conducts a periodic review of the efficacy of service provision, with his/her evaluation covering areas such as ability to respond to the specific needs of this client group in terms of language and other specific concerns, conditions of inpatient facilities and continuation of care.
4. Guard against automatically viewing detained asylum seekers as malingerers and manipulators of the system with the intent of securing protection or release from detention, as this may lead to an underestimation of the needs of individuals with severe mental health problems. In this regard, offering training in cross-cultural and migrant mental health to staff in contact with detainees can help address this potential barrier.

6.2 Inpatient Mental Health Services

5. Focus on gradually developing an inpatient mental health service for detained asylum seekers that is more targeted to the specific needs and concerns of the population of interest, such as issues of past trauma, multiple losses and anxiety and insecurity related to protection issues. The service's capacity to adequately respond to these needs and concerns can be augmented by offering the above mentioned training, and developing and implementing activities that facilitate emotional expression.
6. In line with the need to develop a specialised service, patients with very distinct issues, such as substance abuse, should be accommodated in separate wards.

7. Upgrade present facilities with the aim of fostering a therapeutic environment that is more conducive to the treatment and recovery of individuals with mental health problems.
- a) Tackle the risk of overcrowding by increasing current capacity, possibly by identifying an alternative ward, encompassing a greater number of rooms.
 - b) Change the current situation where the restrictions placed on a detainee’s movement in a psychiatric ward are greater than those imposed in a closed detention centre. In this regard, inpatients should be allowed the possibility to spend the majority of their waking hours outside their room, and be provided with the opportunity to engage in recreational activities.
 - c) The physical conditions within the ward should be addressed so as to create an environment that functions as a therapeutic space, rather than solely a secure space. This can be done by, for example, structuring rooms in a way that ensures conditions that are more hygienic and less degrading (e.g. having toilets outside the room that are easily accessible), equipping common areas with recreational options for reading, listening to music and drawing, and furnishing them with a comfortable seating area where individuals can socialise, watch TV etc.
 - d) A therapy room should be created within, or external to, the ward where psychological therapy and consultation can take place in a private and contained environment, rather than in a utility room, corridor or in a patient’s bedroom.

6.3 Vulnerability Assessment Procedures

8. The provision of social work services in detention centres by a governmental entity separate, and not accountable, to the detention services would go a long way in ensuring a more effective implementation of the vulnerability policy regarding mental health. With a consistent presence in detention and regular face-to-face contact with detainees, this entity would be ideally placed to take charge of the responsibility for identifying and referring detainees for vulnerability assessment. In order to ensure its efficiency, this entity would need to employ mental health professionals and operate in liaison with health service providers, and receive relevant information about detainees receiving psychiatric treatment.
9. Set a definite timeline for the vulnerability assessment procedure that, while being realistic in terms of available resources, is of a short enough duration to keep the risk of further deterioration in the detainee’s mental health after referral to a minimum. It is suggested that this set timeframe should not exceed one month from referral, and should be communicated to detainees, giving them greater control of their situation and thus reducing feelings of helplessness and uncertainty that may aggravate their mental health.
10. Implement a system whereby, as a matter of procedure, a standardised mental health screening is administered to individuals exhibiting indicators of the development of mental health problems such as suicide attempts, drastic weight loss or severe social isolation. This would minimise the chances of individuals with mental health problems slipping through the net, without the need to resort to systematic screening that would be impractical from a resource perspective, and would need to be repeated at different points in time to be effective.

6.4 Provision of the Service of Interpreters/Cultural Mediators

- 1. Develop a system within the national mental health service that ensures the availability of trained interpreters/ cultural mediators for service users requiring them. Adopting a system that utilises cultural mediators would represent a more effective approach as it would target a greater range of the current barriers to effective communication.
- 2. Appointing a language coordinator, tasked with tackling existing language barriers for service users, would help in ensuring that such a system operates effectively.
- 3. Ensure that mental health service providers are consistently able to recruit the services of trained interpreters/ cultural mediators as the need arises, in order to guarantee that the migrants accessing the service can understand and communicate their difficulties effectively.
- 4. Refrain from utilising untrained interpreters (including family, friends, domestic staff and fellow patients) in all consultations with patients.
- 5. Develop internal protocols for mental health staff to guide their work with interpreters and/or cultural mediators, and provide channels through which they can be supported should difficulties arise.
- 6. Encourage mental health professionals to avail of any training offered regarding working with interpreters in mental health settings.

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