Mental health morbidity amongst people subject to immigration detention in the UK – a feasibility study

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Aims:
The UK has one of the largest systems of immigration detention in Europe. The standard of healthcare provision in immigration removal centres (IRC-s) in the UK has been repeatedly cited as cause for serious concern. Despite this, there is very little published research in IRC-s which screen for the full range of mental disorders. The aims of this study were to explore whether it was feasible to conduct psychiatric research in such a setting and to provide an estimate of screened psychiatric morbidity in the male detainee population of an IRC.

Method:
Cross-sectional design with simple random sampling followed by opportunistic sampling. Exclusion criteria included inadequate knowledge of English and EU nationality. Six validated tools were used to screen for the full range of mental health disorders including developmental disorders like Personality Disorder, Attention Deficit Hyperactivity Disorder, Autistic Spectrum Disorder and Learning Disability, as well as for needs assessment. These were the MINI v6, SAPAS, AQ-10, ASRS, LDSQ and CANFOR. Demographic data was obtained using a participant demographic sheet. Researchers were trained in the use of the screening battery and inter-rater reliability assessed by joint ratings.

Results:
101 subjects were interviewed. Overall response rate was 39%. The highest screened prevalence was for depression (52.5%), followed by personality disorder (34.7%), and PTSD (20.8%). 21.8% were at moderate to high suicidal risk. 14.9 and 13.9% screened positive for ASD and ADHD, respectively. The prevalence of depression was significantly higher than a control group in prison. The overall screened prevalence of other mental disorders and suicidality was similar to prison samples. The greatest unmet needs were in the areas of intimate relationships (76.2%), psychological distress (72.3%) and sexual expression (71.3%).

Conclusions:
There should be greater awareness of neurodevelopmental disorders amongst staff in IRC-s. There were limitations to the study like the issue of self-selection, use of screening tools, single-site study, high refusal rates, lack of interpreters, and lack of women and children in study sample. The change to a different model of recruitment using a member of the mental health in-reach team to recruit participants should be employed in future, as well as involvement of all key stakeholders from the outset. The study demonstrates that psychiatric research in IRC-s is feasible. There is a need for a national multi-site prevalence study of at-risk mental health in IRC-s. Such a study should be funded to provide for interpreters and not exclude EU nationals.

Mental Health /NeuroDevelopmental Disorder	Screened Prevalence in the whole sample N = 101 (%)
Depression	53 (52.5)
Personality Disorder	35 (34.7)
PTSD	21 (20.8)
Autism (Autism Quotient- 10)	15 (14.9)
ADHD (Adult ADHD self-report scale)	14 (13.9)
Social Anxiety Disorder	12 (11.9)
Manic episode	10 (9.9)
Mood Disorder with psychotic symptoms	10 (9.9)
Generalised Anxiety Disorder	10 (9.9)
Obsessive Compulsive Disorder	9 (8.9)
Hypomanic episode	8 (7.9)
Alcohol dependence	8 (7.9)
Drug dependence	8 (7.9)
Antisocial Personality Disorder	8 (7.9)
Agoraphobia	7 (6.9)
Panic Disorder With Agoraphobia	4 (4)
Panic Disorder without Agoraphobia	4 (4)
Hypomanic symptoms	3 (3)
Psychotic Disorder	3 (3)
Drug Abuse	2 (2)
Bulimia	1 (1)
Anorexia	0
Any MH disorder from MINI	65 (64.3)
Any MH,neuro developmental disorder or PD	75 (74.3)

Table 1: Prevalence according to screening tests

At-risk Level	IRC %	Published (%)	Comparator	Chi^2	p-value
Depression	52.5	18[1] (suicidal)	Rivlin, 2010	18.778	P <.001**
		7.3[1] (suicidal)	Rivlin, 2010	35.1	P <.001**
PTSD	20.8	5[1] (suicidal)	Rivlin, 2010	7.4	P= <.004*
		2[1] (control)	Rivlin, 2010	11.67	P <.001**
ADHD	13.9	40[1]	Ginsberg et al, 2010	21.48	P <.001**
		6.2[2]	Das et al, 2012	9.1	p = .005*
Autism	15	4[1]	Robinson et al, 2012	27.13	P <.001**
		1.1[2]	Bruga et al, 2012	32.56	p< .001**
PD (cut-off 4)	34.7	14.5[2]	Fok et al, 2013	29.06	P <.001**
Suicide (mod/high)	21.8	13.9[3]	Pluck & Brooker, 2014	2.86	P = .065
Any Disorder (MINI)	63.4	62[1]	Rivlin, 2010	.047	P=.867

Table 2: Summary of Chi^2 tests of the frequency rates for the IRC compared with community and prison populations

CANFOR item	No need or unknown (%)	Met Need (%)	Umet Need (%)
Accommodation	18.8	70.3	10.9
Food	1.0	77.2	10.9
Looking after the Living Environment	18.8	79.2	2.0
Self-Care	24.8	70.3	5.0
Daytime Activities	5.9	48.5	45.5
Physical Health	10.9	48.5	40.6
Physical Symptoms	58.4	30.7	10.9
Information about condition and treatment	62.4	15.8	21.8
Psychological Distress	5.9	21.8	72.3
Safety to Self	40.6	38.6	20.8
Safety to Others	52.5	39.6	7.9
Alchohol	92.1	3.0	5
Drugs	88.1	4.0	7.9
Company	3.0	34.7	62.4
Intimate Relationships	20.8	3.0	76.2
Sexual Expression	26.7	2.0	71.3
Child Care	76.2	20.8	3.0
Basic Education	16.8	65.3	17.8
Telephone	3.0	96	1.0
Transport	43.6	53.5	3.0
Money	42.6	40.6	16.9
Benefits	86.1	7.9	5.9
Treatment	76.2	10.9	12.9
Sexual Offences*	91.1	1.0	7.9
Arson*	91.1	1.0	7.9

Table 3: Frequency of need, met need and unmet need on CANFOR