



Challenges to Providing Mental Health Care in Immigration Detention

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About the Global Detention Project

The Global Detention Project (GDP) is a non-profit research centre based in Geneva, Switzerland, that investigates the use of detention in response to global migration. The GDP's aims include: (1) providing researchers, advocates, and journalists with a measurable and regularly updated baseline for analysing the growth and evolution of detention practices and policies; (2) facilitating accountability and transparency in the treatment of detainees; and (3) encouraging scholarship in this field of immigration and refugee studies.

About the authors

Stephen Brooker is CEO of St. John of God Hospital in Richmond, New South Wales; Steve Albert is a consulting psychologist with experience working with clients with complex trauma, self-harm, and borderline personality disorders; Peter Young is former head of mental health at International Health and Medical Services, the private contractor providing medical care at Australian immigration detention centres; Zachary Steel holds the St. John of God Chair of Trauma and Mental Health, a partnership between Richmond Hospital, the School of Psychiatry UNSW, and the Black Dog Institute. A version of this paper will appear in the forthcoming volume *Challenging Immigration Detention: Academics, Activists, and Policymakers* (Edward Elgar).

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Challenges to Providing Mental Health Care in Immigration Detention

By Stephen Brooker, Steve Albert, Peter Young, and Zachary Steel

Abstract: The global expansion of immigration detention systems creates an imperative for the mental health community to develop specialized models and practices of care. The harmful psychological effects of immigration detention and repeated findings that this practice results in breaches of human rights principles create a complex care setting. The authors employ lessons learned from their professional experiences in Australia, findings in specialized literature, and testimony from health workers and detainees to argue that immigration detention exhibits the qualities of an invalidating environment, wherein responses to a person's emotional experiences are often inappropriate or inconsistent. In such settings the communication of emotional distress is generally ignored or responded to negatively with increasingly harsh responses that fail to address the cause of the distress. An invalidating environment promotes emotional and behavioural dysregulation, which is consistent with the experiences of many people held in immigration detention. Work by mental health professionals provides an important framework for understanding the corrosive nature of immigration detention and suggests a range of clinical approaches that may be adapted to assist in developing resilience to such settings.

I. Introduction: Challenges in Providing Mental Health Care in Immigration Detention

There is a growing imperative for the mental health community to develop specialized models and practices of care for the increasing numbers of people across the globe who are confined in jails and detention centers for reasons related to their migration status. The need for mental health tools to assist people in this form of detention arguably dates back decades, to the mass displacement of Indochinese refugees during the 1970s and 1980s. Refugee camps established to accommodate three million-plus Indochinese refugees across the region transitioned into closed detention facilities by the end of the 1980s and early 1990s. An early willingness to provide resettlement places within countries of the West diminished over the 1980s leading to the Comprehensive Plan of Action, as a part of which refugee assessment was introduced along with a regional tightening of immigration restrictions on displaced persons and the establishment of a network of secure detention facilities. As these refugee camps transitioned into places of detention, it became apparent that there was a widespread impact on the mental health of those held in prolonged detention (Chan, 1987; McCallin, 1992).

Since this time the practice of immigration detention has expanded globally, as documented by organizations like the Global Detention Project, which has reported the use of nearly 2,000 immigration-related detention sites across the globe over the past two decades. Within the United States, which is the most dramatic example, there has been a sustained expansion with between 430,000-470,000 individuals being subject to some form of immigration detention annually during the most recent period compared to numbers as low as 6,000 in 1995 and 16,000 in 1998. Other countries in Europe, Asia, and the Americas have also experienced rapid expansions of their detention operations.¹

¹ For more on the expansion of national detention regimes, see the website of the Global Detention Project, www.globaldetentionproject.org.
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The provision of health care within immigration detention settings is complex and fraught (Silove & Becker, 1993; Thomas, 1993) with health professionals maintaining dual loyalties to the detention facility operators and to asylum seekers and other detainees for whom they have a duty to provide care (Goodwin-Gill, 1986; Zion, 2004). The delivery of health care in immigration detention is arguably more complex than in other institutional environments such as prisons or high care settings where there is a clear context of care and well-established codes of practice. Within prison settings the roles of mental health professionals have developed through a long process of specialization of forensic health services involving the assessment of risk and the treatment of mental health conditions as part of a general prison health service (Collaborating Centre For Mental Health Research And Training World Health Organization, 2011).

Healthcare and especially mental health care within immigration detention facilities occur within a zone that is excised from the usual conventions of clinical transparency and communication. Access to immigration detention is restricted and while subject to external review by statutory authorities (Silove, Austin, & Steel, 2007) is often associated with a pervasive environment of secrecy. Within Australia and in its Offshore Processing Centers in Nauru and Papua New Guinea, this secrecy has been protected by the Border Force Act, which makes it a criminal offence for employees to disclose *entrusted information* that may include details of the clinical environment or care practices within detention. Recent reform has excluded health professionals from the full provisions of the act but they are still subject to operational confidentiality clauses in employment provisions that create a context for mental health care that is fundamentally different to other care settings (Silverman & Massa, 2012). Mental health professionals moreover are witness to a system of containment and “deterrence” that is inconsistent with international human rights norms and expectations (Goodwin-gill, 1986; Silverman, 2014; Silverman & Massa, 2012) and is associated with adverse mental health outcomes for asylum seekers and other detained populations.

This paper grew out of a series of consultations between the authors to examine models of care that can better support the mental health care and wellbeing of asylum seekers and other populations held within immigration detention facilities operated within Australian Territories or as part of the off-shore processing network developed by the Australian Federal Government on Manus Island and Nauru. Over the period of 2012-2015, two of the authors (Stephen Brooker and Peter Young) worked for International Health and Medical Services (IHMS), which was contracted by the Australian Department of Immigration and Border Protection to provide health services for domestic and offshore detention centers. These two authors were employed by IHMS to oversee mental health services across the network of detention facilities in Australia and on Manus Island and Nauru. In Section III, Brooker provides a “personal account” of his experience working for IHMS. Another author (Steve Albert) is a psychologist who has worked extensively with clients with complex trauma, self-harm and borderline personality disorders. He has designed change management strategies for implementing Dialectical Behavior Therapy (DBT) programs across mental health services in order to address institutional factors that contribute to poor mental health outcomes, as well as clinically coordinated DBT programs in public and private hospital settings and training consultations. The fourth author (Zachary Steel) has worked for an extended period of time as a researcher and clinician with asylum seekers and has documented clinical presentations amongst detained and formally detained asylum seekers across multiple publications.²

² See: Momartin, Steel, Coello, Aroche, Silove, & Brooks, 2006; Nickerson, Steel, Bryant, Brooks, & Silove, 2011; Silove, Austin, & Steel, 2007; Steel, Momartin, Bateman, Hafshejani, Silove, Everson, Roy, Dudley, Newman, Blick, & Mares, 2004; Steel, Silove, Brooks, Momartin, Alzuhairi, & Susljik, 2006; Thompson, McGorry, Silove, & Steel, 1998.

The authors employ lessons learned from their professional experiences, evidence provided in specialized literature, and testimony from health workers, refugee advocates, and asylum seekers to argue that immigration detention exhibits the qualities of an invalidating environment. An invalidating environment is one in which a person's emotional experiences are not appropriately responded to or where responses are highly inconsistent. In such settings the communication of emotional distress will be generally ignored or responded to negatively with increasingly harsh responses that fail to address the cause of the distress. The value and contribution of pro-social behavior is diminished, degraded, and minimized. Consequently, an invalidating environment promotes emotional and behavioral *dysregulation*³—an observation that is also consistent with the experiences of many asylum seekers held for extended periods in immigration detention. Work by mental health professionals provide an important framework for better understanding the corrosive nature of immigration detention and suggest a range of clinical responses to better support the mental health of persons subject to detention.

II. Mental Health in Immigration Detention: What the Experts Say and the Evidence Shows

Mental health care within detention occurs within a broad battleground between those who maintain that the existing system and operational policies of immigration detention are necessary for the maintenance of border control and public health and as a necessary, if unpalatable, deterrent; and those on the other side who believe the system is arbitrary, unsafe and an abuse of human rights (Kalt, Hossain, Kiss, & Zimmerman, 2013; Klein & Williams, 2012; Maglen, 2007). In high-income countries such as Australia, it is not uncommon for health and security services related to immigration detention to be tendered to private contractors. This privatization of detention services often has the effect of further obscuring many aspects of immigration detention policy and practice under commercial in confidence arrangements and results in “distancing offices from infractions” (Silverman & Massa, 2012).

Deprivation of liberty within the modern democratic state is traditionally applied to those who have been sentenced to a period of imprisonment for criminal offenses; those who have been found by medical assessment to be gravely affected by mental or behavioral disturbance and unable to safely remain in the community; or those who have been detained and held in remand until charges of criminal behavior can be judicially reviewed. The immigration detainee, in contrast, is held in detention entirely because of an administrative decision by the state as to how it will manage people at a certain stage of their immigration processing. Such an administrative decision will often extend to asylum seekers who also have a right to be protected under international law to seek protection from a nation-state and not be penalized for their mode of arrival. The detention environment contains disparate ethnic and cultural mixes. In many jurisdictions individuals seeking asylum, who are defined similarly as detainees, often live in close proximity with individuals released from the justice system.

Within Australia, professional bodies such as the Australian Medical Association have issued position statements arguing that “prolonged, indeterminate detention of asylum seekers in immigration detention facilities violates basic human rights and contributes adversely to health, particularly mental health.” The Royal Australian College of Physicians (RACP) further states that “detention is harmful to the physical and mental health of people of all ages in the short and long term” (Royal Australian College of Physicians, 2015). Similarly, the Australian Psychological Society (APS) has issued a position statement on the psychological wellbeing of

³ “Dysregulation” is the loss of ability to regulate one’s emotional responses to situations.
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refugees and asylum seekers in Australia “recognizing the vulnerability of asylum seekers, the heightened risk of mental health problems given the psychosocial impact of pre-migration trauma. Furthermore, the system of mandatory detention of asylum seekers in remote detention facilities compromises the ethical delivery of psychological services” (Australian Psychological Society, 2011).

These statements from professional health organizations align with a growing evidence base across a larger body of clinical research and findings of investigations by human rights bodies and statutory authorities, which have found⁴:

- populations subject to immigration detention, such as asylum seekers, are highly vulnerable as a result of forced displacement and prior torture and trauma exposure;
- immigration detention exacerbates existing mental disorders and can independently contribute to the onset of new mental disorders, in particular in cases of continuing indefinite detention;
- there are extreme forms of generated behavior in immigration detention that are not normally witnessed by clinicians in most other settings, including so-called ‘protest behaviors’ like hunger strikes, mass incidents of self-harm, riots, fires, etc.;
- alleged physical and sexual harassment and assaults;
- boredom, learned helplessness, and powerlessness.

Clinicians working in this environment have to learn new skills:

- dealing with longitudinal deterioration related to immigration status and confinement;
- managing high rates of psychotropic use and illicit drug and alcohol use within an institutionalised setting (which is not new but requires adaptive skills).
- responding to patients undertaking hunger strikes, lip-sewing, threats of self-harm and other forms of ‘body-bartering’ associated with perceived injustices;

III. Contracted Mental Health in Australian Immigration Detention: Stephen Brooker’s Personal Account of an Invalidating Environment

I joined IHMS (International Health and Medical Services) in February 2012 as Mental Health Services Manager, later becoming the Director of Mental Health Services. I came to this position from a nursing background after completing my general nurse training in 1989 and working in oncology and emergency departments. I moved into immunology (HIV/AIDS and communicable diseases) where I worked, in different areas, for the next 15 years but which also included the completion of postgraduate training in mental health nursing in 1992. During this period I worked as a front-line clinician, gradually working into senior clinical and then management positions whilst travelling along the way - working in India as a volunteer on an HIV/TB care and support project in Bangalore and Hong Kong with Medecins Sans Frontiers on a needle exchange program for Vietnamese refugees. In 2007 I moved into the area of mental health management and accepted the post of Director of Nursing and subsequently General Manager (GM) of a 44-bed private psychiatric facility. I stayed in the GM post for 4-years where I provided services to people with depression, anxiety and related mood disorders, borderline personality disorders, drug and alcohol issues and those who were at risk of self-harm or of harming others. In these 4 years I supported the hospital’s strong reputation in dealing with substance abuse issues and especially with borderline personality disorder, which is

⁴ See: Coffey, Kaplan, Sampson, & Tucci, 2010; Commonwealth and Immigration Ombudsman, 2013; Hallas, Hansen, Stæhr, Munk-Andersen, & Jorgensen, 2007; Lawrence, 2004; Médecins Sans Frontières, 2010; Procter, De Leo, & Newman, 2013; Silove, Austin, & Steel, 2007; Sobhanian, Boyle, Bahr, & Fallo, 2006; Triggs, 2013, 2015.

characterized by emotional dysregulation and frequent self-injury including cutting, overdoses, exacerbation of injuries and many other forms of behavior difficult to control.

I applied to work in the detention health network as I had extensive expertise working with people from developing countries, was a trainer and clinician, and had managerial experience especially with regard to the development and implementation of policy and procedures, achieving accreditation standards, supporting, retaining and developing skilled staff as well as delivering a quality mental health service. Reading the initial position description, I knew that there were not many clinicians with the requisite skill-set or background that would be able to fulfil the main functions of the role. Prior to my arrival there had been three people appointed (temporarily) in quick succession.

My first few months were a trial by fire. IHMS had limited experience running a comprehensive health service – the organization had developed from an emergency service in developing countries for corporate clients and had been the successful tenderer for the detention health contract in the mid-2000s. They understood medical care, to a certain extent (vaccinations and child health being an area where they struggled to get systems and processes in place), but mental health was new to IHMS. It was, to all intents and purposes, a cursory add-on service to the medically focused health clinics they operated.

The model of care for mental health was run on a ‘banding’ model by site. At the time I joined there were multiple sites each with its own banding model, meaning that a certain number of clients (say 500) would correspond to a certain number of staff (e.g. eight medical and seven mental health). This formula did take account of acuity – a key variable in healthcare. For mental health services, the teams were a mix of mental health nurses, psychologists, and counsellors. Expert visiting psychiatrist time was available for clinic days, and at some sites child and adolescent psychiatrists were also available but were usually limited (one day a week or ‘fly-in, fly-out’ in places such as Christmas Island where a psychiatrist would be deployed for five-days a month). There were also Mental Health Team Leaders (MHTL’s) at each site. The MHTL’s worked alongside their medical colleagues (Clinical Team Leaders) and both reported to a Health Service Manager (HSM) at each site and a Medical Director and an Operations Manager (OMs) who was in overall charge of a number of sites. The HSMs, MDs or OMs had limited or no experience and training in mental health.

After starting in the new role, it became apparent that there was an immediate safety risk in terms of the adequate implementation of the Psychological Support Program (PSP), which was the framework used within immigration detention facilities involving all organizations: Department of Immigration and Border Protection; Serco (the Detention Security Provider, DSP); and IHMS (health provider). The clinical procedures of the PSP were not clear and clinical recommendations were at times ignored. There was also an expectation that IHMS clinicians would interact with the clients in a similar way to other contracted detention service staff, and with the detention service provider failing to recognize that this approach blurred the critical need to distinguish between the role of health care staff and detention security staff.

It was clear that the service lacked basic systems of clinical governance and structures to guide and support staff. We (being myself and the Medical Director for mental health – Peter Young) responded to this by establishing weekly teleconferences, firstly with the MHTL’s, then the psychologists, counsellors, psychiatrists and mental health nurses. The weekly teleconferences were instrumental in allowing a forum to develop where mental health staff could raise issues immediately and discuss these with staff at head office and with colleagues so that lessons could be learned and issues explored. Quite quickly I realized that dual loyalty and ethical issues were

a major concern and stress for staff. There was uncertainty for clinicians in what they could say, do or how to act when faced with an intransigent organization who expected clinicians to prioritize detention operational issues over clinical considerations. Clinical independence, autonomy, and advocacy were at times disrespected or ignored – especially advocacy for improving health status, a key component of clinical care within other settings, but a part of clinical practice that was viewed with suspicion and hostility within immigration detention. Mental health clinicians who spoke openly about the role of the broader environment in causing harm or who were openly critical of the policy were seen or felt to have inappropriately engaged in political advocacy. This usually ended with a contract being cancelled or not being renewed. It was a strange situation where everyone appeared to acknowledge that the environment caused mental health issues and harm but this could not be discussed openly.

The teleconferences were useful in creating a forum for clinicians to discuss the reality of working in health care services within detention. The reality of detention became acutely clear to me during my first ‘tour-of-duty’ around the Australian and off-shore detention facilities. To be frank, I was appalled. I’d come from an environment where recruitment and retention of skilled, motivated staff was a key indicator for the success of the service. I started visiting the teams working across the network of immigration detention facilities, some clinicians started crying when I spoke to them. There appeared to be a culture of bullying and a consistent lack of clinical support for the difficulties experienced by clinicians in these settings. The operation managers of the detention facilities especially were relatively junior, had come from non-health backgrounds, and had not managed a health service or clinicians before. There tended to be a ‘box-ticking’ approach that was divorced from clinical realities and primarily concerned with managing the relationship with the customer, the Department of Immigration. This meant that if you argued, you were excluded, creating a climate and culture of fear.

The issues the mental health teams (MHTs) on the ground had to address became quickly apparent. Depression, anxiety, hopelessness, helplessness, self-harm, and suicidal ideation were common in virtually all centers, although incident rates varied. Acts labelled as ‘protest behaviors’ (cutting, attempts at hanging, overdoses, hunger strikes, ingestion of other substances, exacerbation of existing injuries, refusal of treatment) were relatively common, again to varying degrees. The MHTs struggled with diagnosis and treatment for these individuals but, for me, they resonated as a rational response to an invalidating environment. I saw a clear link to the response I had previously seen displayed by patients struggling with borderline personality disorders in hospital and community settings that did not have appropriate programs of care.

Once we began to have a better understanding of what clinicians were facing we decided to facilitate MHTL national conferences. We organized key speakers, fixing agendas, and focused upon what models of MH care might work within the detention health environment. One thing was clear: there wasn’t much guidance in the research about therapeutic approaches that could work in immigration detention settings. Initially, we thought harm minimization might be the nearest fit, but after consultations with knowledgeable professionals—including senior researchers who knew the field, the population, the transitory staffing model and the political pressures—we considered Marsha Linehan’s Dialectical Behavior Therapy and associated skills targeting emotional regulation and distress tolerance strategies as a possible model for understanding and engaging detainees (see below).

We conducted three MHTL conferences over three years and continued working with staff during site visits, the weekly teleconference’s and individual client and clinician consultation during periods of unprecedented activity. Every three months we found ourselves dealing with other acute situations and were frequently asked to take on other responsibilities and deployment elsewhere. IHMS also lacked a strong model of clinical leadership at a senior level with the

perceived need to respond to DIBP at times undermining the commitment to implementing models of clinical care. With a rotating staffing model, the retention of skilled individuals who had longer-term rapport with clients to support behavior change (a standard approach in generic MH services) was also not possible.

In 2014 as part of contract negotiations with the Department of Immigration, IHMS operational management agreed to include largely arbitrary determinations of how many people on the Psychological Support Program would require an increase in Support, Monitoring and Engagement (PSP-SME), which was set at 10 percent of the client population. This was after a significant cut in staffing numbers due to a new tendering process that further limited the capacity to implement models of care. A ‘Crisis Management’ model developed with a triage system put into place within weeks of the tender being signed, and there was very little opportunity for prevention work to be undertaken. A comprehensive program of group work, for instance, developed iteratively across facilities to support detainee mental health was unable to be implemented under the new model as there was no staff to deliver it.

The capacity to develop models of mental health care was also closely linked to broader issues of clinical governance. In Australia in 2006 a Detention Health Advisory Group (DeHAG) comprising nominated representatives of professional clinical associations was established by the Howard government to provide the Department of Immigration with “independent, expert advice on health policy, standards for health care services, data and reporting, and mental health training” following recommendations made after two high-profile cases of failure in immigration procedures and clinical care that resulted in the wrongful detention of Cornelia Rau and wrongful deportation of Vivian Solon, both Australian citizens. These two cases highlighted the inadequate provision of health care to people within the immigration detention system and demonstrated the risks of a system run with little independent expert oversight. DeHag was transitioned into the Immigration Health Advisory Group (IHAG) early in 2013 which had a broader scope to advise and develop a framework for health care in immigration detention. This independent body was disbanded in late 2013 after nine months in operation at a time when numbers in immigration detention in Australia had surged. The rationale at the time was that the “current pace of policy development ... with the need for definitive health advice often within a short timeframe has diminished the effectiveness and need for ... IHAG.” This decision created a vacuum of clinical governance, resulting in a closed loop between the Department of Immigration and Border Protection administering a highly charged and politically contentious detention policy and the private contractors meeting targets set by the Department of Immigration. The difficulty with the Department of Immigration policing contractors is that it becomes easy to overlook or ignore system failings. Private companies are operationally and financially focused on meeting contractual obligations. This resulted in the 2014 decision to renegotiate health provider contracts but with a significantly reduced staffing model that undermined all of the previous attempts to develop models of care that moved beyond crisis management, mentioned previously in this section. Clinical governance returned to a model of responding to the investigations of external organizations such as the Ombudsman, the Red Cross, and the Human Rights Commission who are able to gain access and ask certain questions about certain cases at certain times.

The dismantling of these independent governance structures has had an adverse impact upon the detention network as a whole and upon the autonomy and independence of clinicians in particular. Inevitably, this leads to less oversight and transparency that adversely affects the health and well-being of detainees. All of these factors came together in a broader detention environment that appeared to invalidate detainees and clinicians by placing detainees at risk of mental health deterioration and undermining standard models of mental health care.

IV. Immigration Detention as an Invalidating Environment

In the four authors' experience, detainees in need of mental health services frequently appear to behave and relate in a manner that parallels the presentation of patients with borderline personality disorder (BPD). This is reflected in features such as the level of distress, pervasive feelings of hopelessness, heightened reactivity and reduced tolerance to environmental stress, hostility and clinical ambivalence.

It is an important contention of this paper that the conditions and environment of detention converge to undermine the psychological integrity of immigration detainees and creates an invalidating environment analogous to that which is thought to be causal in the development of BPD. In attempting to better understand the institutional factors that contribute to this presentation, we draw on the clinical models proposed in recent decades regarding the pathogenic developmental, familial and social environments that appear to be critical in the development of the extreme forms of psychological distress, dysfunction, suicidality and self-harm evident in BPD.

Marsha Linehan and colleagues at the University of Washington have proposed a biopsychosocial model of BPD which proposes that frequent exposure to traumatic events in childhood may affect the biological processes underlying distress tolerance and emotion regulation that increase the likelihood of a higher baseline of emotional arousal, greater reactivity, slower return to basal functioning and problematic means of coping, such as self-injury and impulsivity (Fruzzetti, Shenk, Lowry, & Mosco, 2003). Consistent with the model, the majority of individuals with BPD have histories of trauma, such as neglect, or emotional, physical or sexual abuse (Linehan, 1987, 2014). According to biosocial theory, however, it is invalidation, not abuse or trauma per se, which is requisite for the development of BPD, and it is here that there seems to be an important parallel to the immigration detention setting (Fruzzetti, Shenk, & Hoffman, 2005; Horwitz, Widom, McLaughlin, & White, 2001). An invalidating environment is one in which someone's personal thoughts, feelings, communications and requests are ignored, dismissed, contradicted, trivialized, or not accepted as a valid response to the circumstances (Koerner & Linehan, 1997; Linehan, 1993). Family and social interactions are thought to have a central role in establishing and maintaining this invalidating environment (negative, judgmental, conflictual, erratic, unpredictable, or extreme responses). Caregiver responses which are invalidating may potentiate the effects of abuse and contribute to problematic behaviors. Invalidating behaviors generate confusion and ambiguity over the accuracy or legitimacy of a person's self-description. When this happens to an emotionally vulnerable child, s/he can develop difficulties in labelling their own feelings, or trusting their cognitive or affective responses to stressors.

Validation is identified as a key factor leading to emotional regulation and a subsequent decrease in distress and problematic behaviors. "Validating responses are not necessarily warm or positive, and do not necessarily convey agreement, compliance, or approval; they do convey legitimacy and acceptance of the other's experience or behavior, at least minimally. Thus, validating responses acknowledge or legitimize only valid behaviors."

This DBT biopsychosocial model, while emphasizing the familial and developmental pathways that lead to BPD, offers an important framework for also understanding the role of invalidation in other settings that result in patterns of pervasive emotional dysregulation, unstable attachments, and self-harm. From the early genesis of the model, Linehan and colleagues (Koerner & Linehan, 1997; Linehan, 1987, 1993; Linehan & Wilks, 2015) stressed that pervasive patterns of invalidation can also become entrenched in other settings noting how

the health care setting itself can become invalidating with patients with a diagnosis of BPD becoming labelled, stigmatized and further alienated because of their symptoms. We have witnessed a very similar process occur within immigration detention where the very ambiguity around the basis of detention tends to stigmatize the detainee.

Understandably a national response to asylum seekers carries the dual responsibility of maintaining border security, ensuring the integrity of humanitarian programs, verifying that asylum applications are genuine, on the one hand, while upholding the responsibility and moral necessity to provide asylum and care under international treaty obligations, on the other. It is recognized that applications for asylum occur within a background of uncertainty regarding the validity of the identity, status or claims of asylum seekers. While the refugee determination process appears to be inherently stressful for applicants (Silove, Steel, Susljik, Frommer, Loneragan, Chey, Brooks, Le Touze, Coello, Smith, Harris, & Bryant, 2007), the level of mental health deterioration in that process does not appear to be equivalent or of a similar magnitude to that observed amongst asylum seekers held in immigration detention.

The features of familial settings that have been identified as contributing to the development of BPD have a number of commonalities with detention environment. Within detention, high rates of pre-migration torture and trauma exposure render the detainees vulnerable to the traumatic effects of invalidation. Invalidating care settings often result in BPD patients effectively being punished for emotional displays, which is not dissimilar to a structural response to acts of self-harm in immigration detention that may lead to extended periods of exclusion and solitary confinement. The intermittent reinforcement of emotional displays tends to promote further dysfunctional behavior. Importantly, the lack of critical support provided within an invalidating environment can lead to the development of an erratic dialectic; swinging between poles of emotional suppression to comply and emotional and behavioural outbursts to communicate distress. These oscillations between the extremes of emotionality and inhibition contribute to problems in effectively communicating emotions and are often confusing to friends, relatives, and caregivers as well as health professionals. These extreme emotional reactions can have a slow return to baseline and lead to what Linehan calls the dialectical of individuals being in an “unrelenting crisis” and “inhibited grieving” where individuals feel unable to cope with the distress of negative feelings, in particular in the context of loss and grief (Linehan, 1987, 1993; Linehan & Wilks, 2015). The emergence of problematic behaviors (impulsivity, anger, self-harm, etc.) of a chronically deregulated individual often creates immediate demands on others; straining or undermining the relationship. Within in detention, such behaviors can lead to detainees becoming stigmatized by a history of erratic or impulsive, self-harming behavior. In such settings, both caretakers and detention staff may minimize communications of emotional distress, be blaming, or judgmental thus creating a vicious cycle of increased distress, a sense of abandonment and hopelessness and an escalation in subsequent problematic behaviors (Linehan, 1993). Impulsive behaviors often function as a short-term escape from distressingly high levels of unbearable emotional arousal arising from ongoing experiences of invalidation (Fruzzetti, Shenk, & Hoffman, 2005). These two broad dimensions of emotion dysregulation and impulsive aggression are associated with self-harm and suicide attempts (Fruzzetti, Shenk, & Hoffman, 2005).

V. Non-suicidal self-injurious behaviors

A significant body of research indicates that non-suicidal self-injurious behaviors develop in response to extreme distress (Fiske, 2016; Kendall, Taylor, Bhatti, Chan, & Kapur, 2011; Morrissey, 2015). While self-injury is not necessarily linked to suicidal intent, a history of self-

injury is a significant risk factor for suicide attempts and repeated self-injury incidents are associated with an increased risk of suicide (Zahl & Hawton, 2004). Care takers confronted with self-injury may find it particularly challenging not to react “in a judgmental, critical or even punitive manner” (Morrissey, 2015, p. 63) and as a result, people who self-injure may be criticized, punished and invalidated—a pattern that, as we have noted, is also likely to occur in immigration detention (Morrissey, 2015).

Within detention, self-injurious and parasuicidal behaviors at a certain level of severity are likely to lead to periods of exclusion, containment, isolation or restraint, which is likely to further invalidate underlying distress. They are labeled as protest behaviours rather than as symptoms of psychological distress and mental health impairment. Moreover, initial factors associated with the distress underlying such acts will rarely be subject to review or open to modification in such settings. It is not surprising that suicidal behaviors have been linked more to the immigration process rather than to pre-existing psychiatric illnesses, which can be managed with an effective clinical setting (Bursztein Lipsicas, 2012; Fiske, 2016).

VI. The Dialectical Behavior Therapy (DBT) approach to intervention

A major milestone in the advancement of psychological interventions for people with a history of chronic self-harm and suicidal urges has been the development of DBT primarily for people diagnosed with borderline personality disorder. More recently DBT has been applied to other groups, including those immersed in other potentially invalidating environments such as remand and prison settings (Fasulo, Ball, Jurkovic, & Miller, 2015; Shelton, Sampl, Kesten, Zhang, & Trestman, 2009).

DBT’s biosocial theory maintains that an environment that enforces a pervasive pattern of invalidating the individual is a key component of the development and maintenance of the individual’s deficit in their capacity to regulate their emotions. Invalidating communications and behaviors tend to increase the frequency, intensity, and duration of emotional and behavioral reactions (Linehan, 1993). DBT aims to balance a focus on behavioral change, with acceptance, compassion, and validation (Swenson, Torrey, & Koerner, 2014). At an individual level DBT teaches several modules of skill sets:

- Emotion Regulation
- Distress Tolerance
- Interpersonal Effectiveness
- Mindfulness

While problematic behaviors such as self-injury are thought to function as a means of escape from short-term emotional distress, DBT teaches emotion regulation skills that serve the individual’s long-term goals of a life worth living, as well as the short-term goals of feeling better and tolerating current distress so that they can survive a crisis without making it worse. Importantly, blame is not placed on the individual suffering emotional distress (Fruzzetti, Shenk, & Hoffman, 2005).

At the heart of DBT is the concept of dialectics: the belief that a more useful, more realistic resolution of dilemmas is obtained from a consideration of the goals and concerns of each polar perspective. Validation requires, at a minimum, a sincere listening to, and empathic consideration of, the concerns and position of each stakeholder. Within the immigration detention environment, relevant stakeholders include the asylum seeker, the detention administration, security personnel, and clinicians. As with any significant organizational change, attending to the wider organizational context and obtaining the buy-in of key stakeholders is

essential for successful change from DBT programs. It is critical to be able to listen to and address the goals and concerns of all stakeholders, identify competing goals, and be able to articulate how any health care program changes will benefit all stakeholders, along with transparently communicating the pros and cons of proposed initiatives. A key step in organizational change programs is a cultural audit of all key stakeholders gathering data such as attitudes and behaviors towards detainees to identify factors that enable or undermine mental and physical health care.

As systemic invalidation and stigmatization are frequently cited by self-injury and suicidal clients who visit public and private health facilities (Hazelton, Rossiter, & Milner, 2006; Linehan, 1993; Long, 2013), these themes are an important component of a cultural audit. A cultural change program would, therefore, highlight the benefits from the perspective of each stakeholder in the system, to be aware of, and minimize or eliminate invalidating language or behavior.

The sustainable implementation of a therapeutic model of mental health care into an immigration detention and health care system requires all stakeholders receiving an appropriate level of education into the rationale for the intervention, the benefits to their group of stakeholders, to the detainees as well as the system as a whole, a common understanding as to what helps and hinders these goals, and the detainees' welfare and a common language which minimizes invalidation and maximizes improved mental health and welfare of detainees

testimony and documented by a growing body of research

Table 1: Factors that mental health managers need to consider in approaching delivery of Mental Health Care in immigration detention

<div><div>Detention a shifting environment</div><div><ul style="list-style-type: none">A shifting population – numbers flexingA shifting workforce – remote centres, deployment, length of contractsShifting clinical needs – paediatrics, maternity/length of stay: mental health and self-harmShifting clinical expertize – training and education, supervision and support<p>Normally health services increase staff if there is increased need and they can do this quickly by using bank or agency staff. In remote centers there is negotiation and compromise with additional delays for deployment.</p></div></div>	<div><div>Working out a Clinical Staffing Model</div><div><p>A model of staffing:</p><ul style="list-style-type: none">What are ideal ratios of client population to staff?What acuity measures are needed to trigger an increase in staffing? Should they relate to:<ul style="list-style-type: none">TransfersA rise in mental health concerns including self-harm or suicideThe needs of families, children, people with disabilities or chronic health issuesWhat staffing model of mental health staff to medical staff are needed?Within a mental health team what professions are needed, and what focus on prevention vs. treatment?</div></div>	<div><div>What do clinicians need when working within the immigration detention setting?</div><div><ul style="list-style-type: none">a staffing model that relates to the clinical needs of the populationreinforcement that their focus is on client careclearer understanding of their role related to political boundariesclinical supervisiona framework for ethical discussions and debateongoing training and educationstrong leadership, with leaders focused on client careindependent oversight</div></div>		
<div><div>Inter-Agency Communication</div><div><ul style="list-style-type: none">Establishing and maintaining independent clinical governance and review.Communication of health priorities to detention and immigration staff.Role differentiation between health, security and immigration.Procedures to triage and escalate based on clinical urgency.</div></div>	<div><div>Multi-Disciplinary Mix</div><div><table><tr><td><ul style="list-style-type: none">PsychiatristsPsychologistsMental Health NursesCounsellorsTherapists</td><td><ul style="list-style-type: none">Diversional programOccupational trainingArt and Movement therapies</td></tr></table></div></div>	<ul style="list-style-type: none">PsychiatristsPsychologistsMental Health NursesCounsellorsTherapists	<ul style="list-style-type: none">Diversional programOccupational trainingArt and Movement therapies	<div><div>Clinical Complexities of Detention</div><div><ul style="list-style-type: none">longitudinal deterioration related to immigration status and confinementboredom, learned helplessness and powerlessnesshunger strikes, lip-sewing, threats of self-harm and other forms of ‘body-bartering’ due to perceived injusticeInter detainee conflict and aggressionalleged sexual harassment and assaultsillicit drug and alcohol use within an institutionalised setting. This is not new but requires adaptive skills</div></div>
<ul style="list-style-type: none">PsychiatristsPsychologistsMental Health NursesCounsellorsTherapists	<ul style="list-style-type: none">Diversional programOccupational trainingArt and Movement therapies			
<div><div>Service Delivery Logistics</div><div><ul style="list-style-type: none">Staff RecruitmentStaff RetentionClinical documentation and TechnologySupply-Chain</div></div>	<div><div>Leadership and Support</div><div><table><tr><td><ul style="list-style-type: none">Leadership and SupportManagersMeetingsRostersPolicies & Procedures</td><td><ul style="list-style-type: none">Education & TrainingEthicsClinical supervisionWHSPeer SupportHuman Resources</td></tr></table></div></div>	<ul style="list-style-type: none">Leadership and SupportManagersMeetingsRostersPolicies & Procedures	<ul style="list-style-type: none">Education & TrainingEthicsClinical supervisionWHSPeer SupportHuman Resources	<div><div>Identifying Vulnerable Groups</div><div><ul style="list-style-type: none">History torture and traumaWomen, children, UAMsPersecuted ethnic groupsComplex health difficultiesFamily at risk in country of originExtended stay in detentionPrevious mental health problemsNegative refugee decisionEngagement in protest behaviour</div></div>
<ul style="list-style-type: none">Leadership and SupportManagersMeetingsRostersPolicies & Procedures	<ul style="list-style-type: none">Education & TrainingEthicsClinical supervisionWHSPeer SupportHuman Resources			
<div><div>Risk Management</div><div><ul style="list-style-type: none">Assessment and risk identificationDe-escalation policy and trainingTriggers and procedures for transfer and admissionCritical incident review proceduresStructured follow-up following clinical episodes</div></div>	<div><div>Method of Clinical delivery</div><div><table><tr><td><ul style="list-style-type: none">1-2-1GroupOutreachClinic-basedEmergencyBooked</td><td><ul style="list-style-type: none">Walk-inTelehealthHelplinesFamilyChild</td></tr></table></div></div>	<ul style="list-style-type: none">1-2-1GroupOutreachClinic-basedEmergencyBooked	<ul style="list-style-type: none">Walk-inTelehealthHelplinesFamilyChild	
<ul style="list-style-type: none">1-2-1GroupOutreachClinic-basedEmergencyBooked	<ul style="list-style-type: none">Walk-inTelehealthHelplinesFamilyChild			

VII. Mental Health Care in Immigration Detention: Between Politics and Care

Clinicians newly recruited to work in immigration detention environments face unforeseen risks they are unlikely to have experienced before. From the outset, they are likely to witness the mental deterioration of patients under their care. Clinical boundaries and roles have not been clearly enunciated and the broader environment invalidates clinical and professional autonomy that is part of standard models of care (Essex, 2016; Isaacs, 2016; Steel, Mares, Newman, Blick, & Dudley, 2004). The political nature of immigration detention and the relationships between health professionals, security staff and immigration officials (as well as external organizations and advocates) can shift clinical thinking into a framework dictated more by security than by the best interest of the patient.

The many challenges that face health care professionals have been highlighted by the Royal Australian College of Physicians, which “acknowledges the significant ethical issues related to providing care in detention, and the tension in defining a standard of care. Doctors and health professionals working within held detention are exposed to significant stress and trauma, and resources are required to ensure appropriate support, supervision and self-care” (Royal Australian College of Physicians, 2015). The RACP further states that: ‘Many health professionals who work with asylum seekers and refugees work in isolation’. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) “advocates that more support must be given to ensure better service provision and retainment of long term staff. With detention center and health staff witnessing stress, violence, self-harm and suicide attempts, it is imperative that staff are provided with proper mental health support” .

The global expansion of immigration detention creates an imperative on the mental health community to consider models and practices of care that attempt to address the mental health needs of immigration detainees. The overwhelming evidence of the psychologically harmful effect of immigration detention on affected populations and the repeated findings that the practice of immigration detention results in breaches of human rights principles create a complex care setting.

Table 1 above outlines a range of contextual factors, issues and staffing matters that are likely to emerge as critical considerations in developing a mental health service program in immigration detention. The categories and variables listed are not exhaustive but aim to identify some areas that are specifically relevant in developing systems of clinical governance and care frameworks within an immigration detention environment. This section addresses in more detail a few of the salient points.

Any attempt to provide health care within immigration detention must be cognisant of the large body of mental health research with detained populations, as well as clinical experience that suggests that a large proportion of clients will be in some form of distress, particularly as periods of detention increase. The development of an immigration detention model of health care, therefore, should be titrated towards mental health alongside the provision of an effective, responsive general medical service.

The complex dual loyalties facing health care systems and individual clinicians working in immigration detention represent a major challenge to clinical independence, integrity, and the welfare of staff. It is critical in these circumstances that the nominated health provider remains independent of the detention service provider. This facilitates differentiation between health staff entrusted with patient care and advocacy and the broader environment of detention focused on

operational and security issues that may not be in the best interests of detainees. From the perspective of detainees, the health care worker is part of a system that deprives them of their liberty and likely has been the cause of substantial distress, harm and possible abuse. The health care worker may not be able to be fully trusted and differentiated from this environment of probable harm. This dynamic may cause a tension that undermines the effectiveness of therapeutic interventions.

The repeated failures of health care that have been documented within immigration detention indicate that health services under the currently contracted arrangements are unable on their own to prevent systemic health care failures. The tendering relationship between government agencies and contractors limits the capacity of health care organisations alone to influence the basic structure of health care provision which establishes the framework of care. This underscores the need for robust and independent clinical governance structures including the critical role of an independent expert body overseeing all aspects of health care in detention including optimal staffing levels, incident investigation, review and public reporting (Phillips, 2010).

Working within immigration detention places enormous stress on clinicians, who are exposed to severe mental health acuity with limited capacity to address key psychosocial stressors. It is essential for staff welfare that they have a place to discuss factors associated with clinical care in this setting without being considered to have crossed some imaginary line into activism. Retention and support of staff should be a priority with access to clinical supervision considered as an essential requirement of working within these settings. Other peer support opportunities should also be encouraged such as developing processes to support clinical discussion and review within and between detention facilities. It should be noted that clinical models such as DBT that work with populations with high levels of clinical acuity include weekly clinical consult meetings and supervision as a fundamental element of service delivery—a model that may provide a template to support the provision of care within these settings. Clinicians also need access to appropriate training to support their work within these settings. Variations in the nature, reason, and operation of detention require approaches tailored to the jurisdictional context of detention. There are a number of existing resources particularly valuable for staff such as models of trauma-informed care and mental health service provision with diverse cultural groups. There have also been important recent initiatives in the development of tools and clinical guidelines for professionals working with conflict-affected populations within humanitarian settings which have relevance for the care of asylum seekers that are often subject to immigration detention.⁵ A useful international resource for asylum seekers who have been exposed to torture is the International Rehabilitation Council for Torture Survivors.

Notwithstanding these resources, at a practical level, there is little to guide the mental health practitioner in identifying mental health interventions that can support the mental health and wellbeing of detainees and ameliorate the iatrogenic effects of detention. A range of therapeutic interventions have been identified that have demonstrated effectiveness in working with refugees and asylum seekers, with the strongest evidence for Cognitive Behavior Therapy, Narrative Exposure Therapy (NET) and Testimonial psychotherapy. For the most part, these interventions have been applied in settings where refugees are in a place of safety or have been permanently resettled. The Australian Psychological Society position statement on the psychological wellbeing of refugees and asylum seekers in Australia highlights the challenges facing psychologists and other mental health professionals noting that “psychological

⁵ Lahiri, van Ommeren, & Roberts, 2016; Semrau, Van Ommeren, Blagescu, Griekspoor, Howard, Jordans, Lempp, Marini, Pedersen, Pilotte, Slade, & Thornicroft, 2012; Silove, 2013; The WHO Department of Mental Health and Substance Abuse, 2016; Tol, Barbui, Bisson, Cohen, Hijazi, Jones, de Jong, Magrini, Omigbodun, Seedat, Silove, Souza, Sumathipala, Vijayakumar, Weissbecker, Zatzick, & van Ommeren, 2014; Tol & van Ommeren, 2012; Ventevoel, van Ommeren, Schilperoord, & Saxena, 2015.

interventions are unlikely to be effective within systems that cause harm” (Australian Psychological Society, 2011). There is a broad evidence vacuum to guide mental health workers in identifying treatments that may be of use. Some evidence emerges from the small number of studies that have been undertaken with asylum seekers who are still in the refugee determination process and hence subject to ongoing stress. In one study the authors identified five components of treatment that were helpful namely: promoting engagement; acquiring coping skills; connecting with personal strengths; connecting with others; and identifying future support.

Another parallel area that may provide some guidance to clinicians and clinical managers working in detention has been the attempt to develop psychological interventions to support conflict-affected populations affected by ongoing risk to violence. The authors conclude that it is “possible and desirable to offer psychosocial support to survivors of organized violence and torture in ongoing situations of continuous traumatic stress”, but underscored the importance for clinicians to work with the participants to create a sense of safety for clinical engagement to occur. It may be that third wave cognitive-behavioral therapeutic interventions (Ost, 2008), such as DBT, that promote skills training in mindfulness practice and other emotional regulation strategies allow immigration detainees to better cope with the distress from prolonged detention. The use of DBT amongst incarcerated forensic populations has demonstrated some level of effectiveness (Black, Blum, McCormick, & Allen, 2013; Gee & Reed, 2013; Tennant, 2010) and could be helpful in supporting those subject to detention manage the distress associated with detention.

VIII. Conclusion: Providing Care and Bearing Witness

Immigration detention represents an enormous challenge to the mental health community. The health and mental health communities need to maintain a commitment to documenting the harms associated with this practice and to advocating for the use of more humane approaches to the management of irregular migrants. When used, immigration detention should be a practice of last resort, open to judicial review, be time limited and applied on an individualized assessment rather than to a whole class of individuals, as it is often currently the case. Reviews of health and mental health and health services within detention demonstrate that operational pressures frequently undermine the capacity of mental health services to respond to the mental health needs of detained populations. The work of mental health clinicians is also affected by dual loyalty conflicts that undermine the capacity of clinicians to provide mental health care. These facts underscore the complex health care environment that faces the mental health clinician working within these environments.

Notwithstanding these observations we have argued that there is a role for mental health professionals within detention. We have aimed to identify a range of practical responses that can be developed to help ensure that mental health services within detention can be independent, autonomous, and sufficiently resourced to provide care that benefits affected populations even if they may be unable to fully ameliorate the negative effects of the detention environment. Importantly, there is emerging evidence from multiple settings to suggest that populations affected by on-going adversity can benefit from psychological support strategies. This paper has proposed a model of care in which the role of an invalidating environment is a critical lever for supporting the mental health and wellbeing of asylum seekers. Third wave mental health interventions include recognition of the critical role that person x environment interactions have in moderating mental health and wellbeing. They recognise that mental health professionals must attempt to play a key role in shaping environment change management strategies, by undertaking consultation and education with other key stakeholders in the environment

including security and operational staff. Such initiatives should aim to reduce stigmatizing attitudes around “problematic behaviours” and also highlight that de-escalation processes that aim to minimise key elements of the invalidating environment would not only benefit the wellbeing of asylum seekers but enhance workplace safety and staff welfare. While liberal democracies and other nation states continue to rely on the practice of immigration detention of vulnerable populations, we argue that there is a critical role for mental health professionals not only to document the harms of this practice, but to directly support those subject to detention.

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