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ARTICLE

Immigration policy: implications for mental health services

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SUMMARY

Immigration is increasing and government policies are shifting. Clinicians need to be aware of the mental health needs of immigrants and the challenges of delivering appropriate care. In certain circumstances there are potential conflicts between doctors' clinical, ethical and legal responsibilities. Detention of refugees and asylum seekers may have a detrimental effect on mental health and can result in significant psychiatric morbidity. Ongoing management of foreign nationals following hospital treatment may be complicated by the threat of deportation and its implications for the patient's mental health.

DECLARATION OF INTEREST

None.

Migration is a growing global phenomenon. The United Nations estimates that, in 2005, 191 million people were living outside their country of birth (United Nations 2006). This creates multiple challenges. As immigrant numbers have grown so has political interest and in recent years immigration has been a central issue for governments. Over the past 10 years five major immigration-related Acts of Parliament were introduced in England and Wales. In recent policy and statute, the emphasis is on greater control of migration, with the intent of widening the gap between skilled economic migrants and people here illegally (Home Office 2007).

Although the influx of economic migrants has, in the main, been viewed as beneficial, increased immigration of other groups has led to expressions of concern about potential effects on services and on the broader social fabric of the UK. Politicians from all major political parties have spoken publicly of these concerns. Tabloid newspapers tend to publish stories highlighting apparent negative effects of immigration, for example the maternity ward turning away British mothers to make room for immigrants reported in the *Daily Mail* (Martin 2008). Broadsheets have also raised concerns, albeit in less emotive terms, for example Bawden in the *Guardian* (2007), who wrote on the impact of immigration on public services.

Increasing immigration affects many aspects of social and healthcare provision. A recent systematic review of the literature concluded that there is evidence to suggest an independent adverse effect of detention on the mental health of asylum seekers (Robjant 2009).

This article will outline some of the possible implications of shifting immigration policy for mental health services. It will provide an overview of migration to the UK and comment on the difficulties inherent in delivering healthcare to asylum seekers and the particular issues regarding immigration removal centres. It will also examine the ramifications for mental health services of treating foreign national patients.

Definitions

Issues surrounding immigration and immigrants are fraught with complications: moral, ethical and practical. The jargon employed may be complicated by the intent behind it. Terms used for instance by newspapers may be different from those found in official documents. The term most commonly used in the latter is 'foreign national'. We have been unable to find any corresponding formal definition in the UK but the US Department of Homeland Security defines a foreign national as an individual who is a citizen of any country other than the USA. *Wikipedia* defines a foreign national as 'a person present in a country who does not currently have the right to permanent residency of that country' (www.wikipedia.org). Such people may be divided loosely into two groups, those here legally and those here illegally.

Legal immigrants

The 'legal' group of foreign nationals can be subdivided into refugees, asylum seekers and economic migrants both from within the European Economic Area and elsewhere.

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Refugees

A refugee is defined by Article 1 of the Geneva Convention as:

> A person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.

Asylum seekers

'Asylum seeker' is a widely used term. It is not synonymous with refugee, although many asylum seekers will fulfil the criteria for refugee status. It can be defined as someone who has left their country of origin and is seeking formal refugee status in another country but who has not yet been granted it.

Economic migrants

An economic migrant is a person who chooses to enter another country for the purposes of paid employment. European Economic Area migrants have the right to enter, live and work in the UK without applying for special permission. Non-European Economic Area migrants must meet requirements for one of the various defined categories to be able to work here. Doctors, for example, apply as highly skilled workers. The UK Border Agency's website provides detailed information on these categories.

Illegal immigrants

An illegal immigrant is simply someone not meeting the legal requirements to stay in a country. Included in this group are:

- those who have evaded border control to enter the country without permission;
- those who breach a condition of leave granted, for example working in paid employment while holding only a study visa or failing to leave at the end of a permitted period of residence; and
- those who commit a criminal offence that affects any legal right they may have had to stay.

Individuals who apply for asylum either at a port of entry or while already in the country but are refused fall somewhere in between the legal and illegal groups. They have some rights of access to benefits, housing and medical care but the extent of this is a matter of ongoing debate.

Table 1 summarises the 2008 statistics on immigrants in the UK.

Policy and healthcare provision

Government policy over the past 5 years has focused on greater control of migration to the UK. This follows two paths: to regulate 'legal' migration more strictly and to reduce 'illegal' migration. The formation of the new UK Border Agency following the division of the Home Office in April 2008 brought together the work previously done by the Border and Immigration Agency, customs detection by Her Majesty's Revenue and Customs, and UK visa services from the Foreign and Commonwealth Office. Some of the associated policy changes affect healthcare provision, particularly within mental health services.

Deporting foreign national offenders

The government has moved to remove any foreign national, whatever their legal status, who 'causes harm'. This is an issue that may affect both general and forensic mental health services. Following widespread adverse media reporting of foreign national prisoners being released without being considered for deportation, there have been marked changes in systems and practice. Within the prison service there is now a clear pathway for identifying all potential foreign nationals by prison governors and this information is passed on to the UK Border Agency for a decision on possible deportation. The UK Border Act 2007 clearly defines which prisoners will automatically be deported but is less clear on mentally disordered offenders.

Healthcare for illegal immigrants

Policy on access to health services has shown a clear move towards restriction of free provision for the 'illegal' group of foreign nationals, including

TABLE 1 Statistics on immigrants in the UK, 2008

Total immigrants (to UK for at least 1 year)[a]	590 000
Net immigrants	163 000
Number of non-European Economic Area nationals admitted as work permit holder or dependant[b]	112 000
Applications for asylum (excluding dependants)	25 930
Initial decisions	19 855
Recognised as refugee and granted asylum	20%
Not recognised as refugee but granted exceptional leave to remain, humanitarian protection or discretionary leave	11%
Refused asylum or other leave status	69%
Total asylum removals and voluntary departures (excluding dependants)	12 040

a. There are of course no official figures for illegal immigrants. In 2005, the Home Office estimated the 2001 figure at 430 000 (Woodbridge 2005).
b. People from the European Economic Area do not need a work permit.
Source: Home Office (2009).

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failed asylum seekers. This was laid out in a Department of Health document published in 2004 and updated in 2007 (Department of Health 2007). However, at judicial review in April 2008 it was ruled that a failed asylum seeker could be classed as 'ordinarily resident' and could therefore qualify for access to free healthcare (*R v. West Middlesex NHS Trust* 2008).

Ordinarily resident immigrants

The term 'ordinarily resident' is defined in case law, albeit with some lack of clarity, as 'for settled purpose as part of the regular order of their life'. The judicial review stated that temporary admission to the country could be enough to fulfil the 'lawful' aspect of the criteria (*R v. West Middlesex NHS Trust* 2008). However, the Court of Appeal upheld an appeal by the Department of Health against this decision (*R (A) v. Secretary of State for Health* 2009). It found that failed asylum seekers cannot be held to be ordinarily resident and therefore do not have a right to free healthcare provision. The Court did find that the current Department of Health guidance is unlawful because of its lack of clarity. The Court held that trusts have both the discretion to withhold treatment pending payment and also the discretion to provide treatment when there is no prospect of paying for it.

Charging patients

As a result of this ruling, the treatment of failed asylum seekers will not be funded by primary care trusts. Mental health trusts therefore take the responsibility of whether to charge patients and, if they do, to pursue payment directly from the patient. The Department of Health has published temporary guidance for trusts (Flory 2009) which should be read in conjunction with the guidance on implementing charges (Department of Health 2007) that came back into force following the appeal. In this, the Department of Health stated their intention of redrafting the 2007 guidance in autumn 2009 but an amended version has not yet been published. The temporary guidance states that the trust must decide which of three categories treatment falls into: immediately necessary, urgent or non-urgent. Any treatment should be limited to that which is necessary to enable the patient to return to their country of origin. The assessment should be done on a case-by-case basis and include consideration of the likely timespan for the person to return to their country of origin. The treating clinician should be part of the decision-making process. Payment should be sought before any non-urgent treatment is given and, if possible, while awaiting urgent treatment. Immediately necessary treatment is not exempt from charges but should not be delayed while payment is sought; instead action can be taken after the treatment.

Decision-making

Following the Court of Appeal ruling, many psychiatrists will be involved in this decision-making process at some point, whether for in-patients, out-patients or for people assessed under the Mental Health Act 1983. Every person seen in a clinical setting should be asked the same starting questions to guide whether further exploration of immigration status is necessary. Asking these questions of everybody is vital to avoid breaching Article 14 of the European Convention of Human Rights (which prohibits discrimination).

Given the nature of mental illness the decision as to which category treatment falls into will rarely be simple. The guidance gives a great deal of detail on how to ascertain immigration status and collect fees but little on how to assess treatment need. It does make it clear that just because treatment is 'clinically appropriate' this does not mean it should be provided if fees cannot be paid. Presumably, an initial clinical assessment will always be necessary to enable the decision to be made. Some doctors find it hard to identify people for whom treatment is clinically appropriate but not proceed with this treatment because it is not urgent and the person cannot or will not pay. People detained under the Mental Health Act 1983 are exempt from charges. Some of them will be liable for Section 117 after-care following discharge. Jones (2008) states that the duty to provide aftercare was not altered by any provision of the Nationality, Immigration and Asylum Act 2002 and therefore holds for all categories of foreign nationals. The Court of Appeal ruling should not affect this duty.

The legislation underlying charges for overseas visitors is not new. The statutory provision is set out in Section 121 of the National Health Service Act 1977 (as amended by Sections 7(12) and (14) of the Health and Medicines Act 1988). Regulations were first published in 1989 and have been amended several times since. However, as the drive towards greater control of migration grows and as budgetary control is increasingly devolved to healthcare trusts, it is likely that there will be increased awareness and implementation of the guidance within trusts. It remains to be seen how this will be managed in a fair and equitable way, given that some trusts will be affected to a much greater extent than others because of local population demographics.

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Humanitarian and ethical issues

Doctors in both primary and secondary care have expressed concerns about the humanitarian and ethical implications of moves towards charging failed asylum seekers for non-emergency healthcare (Heath 2008). The charity Medsin (Cassidy 2008) reported that three-quarters of submissions from healthcare providers to the government consultation process expressed concerns. Some felt that the move towards charging this group, who receive no benefits and do not have the right to work, for healthcare amounts to depriving them of their right to the highest attainable standard of health as guaranteed by the International Covenant on Economic, Social and Cultural Rights. Others felt that expecting practitioners to deny healthcare to those who cannot pay contravenes the first line of the duties of a doctor in *Good Medical Practice*: 'make the care of your patient your first concern' (General Medical Council 2006). The counter argument is that failed asylum seekers are not contributing to public services via taxes and therefore by receiving free healthcare could threaten the viability of public health services.

Guidance for practitioners

There has been considerable debate on this topic, particularly in the *Lancet* and the *BMJ*, for example Sheather's *BMJ* blog in 2008 and the *Lancet* editorial in 2007. The British Medical Association (2008) has produced guidance in an attempt to provide some clarity. It highlights the fact that doctors play an essential role in providing care to asylum seekers, who are arguably one of the most vulnerable groups in society, and states that it is not the responsibility of individual medical practitioners to make decisions about the immigration status of patients or any charges that might be made. Each trust should have an overseas visitors manager, responsible for making these decisions.

This does not, however, ease the practical clinical dilemmas of how to manage complex mental health problems, particularly when health authorities may deny patients access to follow-up care. Provision of medical treatment depends not only on government policy but takes into account other legal and ethical considerations. Guidance for medical professionals from the General Medical Council, British Medical Association and professional colleges all includes advice on the avoidance of discrimination and respect for cultural diversity.

Delivering healthcare to asylum seekers

Once an individual's application for asylum is refused, many sources of income and support are withdrawn. A small number may qualify for support under Section 4 of the Immigration and Asylum Act 1999 but even this consists only of accommodation and vouchers for basic provisions such as food and toiletries (Kelley 2006). Given the resulting destitution and social isolation, coupled with the uncertainty of the removal process, it is understandable that people may experience psychological distress and be at increased risk of mental illness, as has been explored in the pages of this journal (Bhugra 2001). Equally this is precisely the high-risk time that access to all but emergency healthcare may be withdrawn. An example of what might be the result of such a situation is given in Box 1. The Royal College of Psychiatrists (2007: p. 8) has stated that 'It would be appropriate, humane and in the interests of public health for refugees and asylum seekers to retain free access to health and social care while they are in the UK even if their application has failed.

BOX 1 Case study: providing healthcare for failed asylum seekers

A 31-year-old Chinese man arrived in the UK 4 years ago. He applied for asylum but this was refused 8 months after his arrival. Since that time he has not received any benefits or vouchers. He has been homeless and has survived on handouts from the local Chinese community. He reported that he has contacted Home Office departments on numerous occasions but has been told that there is nothing that can be done. He became depressed and on a recent visit to the local Home Office department threatened to kill himself because he felt hopeless about the future. The police were called and a Mental Health Act assessment was carried out at the police station. He told the assessors that he was prepared to go back to China if necessary because he could not live like this any longer. It was deemed that he did not require admission to hospital. It was difficult to arrange follow-up for him because he did not have a general practitioner or an address (the homeless hostels refused to take him as he was an illegal immigrant).

The diverse group that falls under the banner of asylum seeker has complex needs. A paucity of adequate translation services and poor continuity of care during dispersal are only two of the additional challenges encountered. Given the high level of need and the low level of resources, it is currently difficult to provide an adequate healthcare service for asylum seekers.

Immigration removal centres

The UK Border Agency is charged with enforcing the UK national immigration policy. It has a stated commitment to 'further strengthen the border,

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count people in and out of the country and target criminals' (UK Border Agency 2009a). One of the UK Border Agency's 'pledges for 2009' is to extend its capacity in immigration removal centres by opening a new facility, near Gatwick, housing up to 420 'illegal immigrants not playing by the rules' (UK Border Agency 2009b). In 2008, 16 310 people were removed from the UK after being held in detention centres under Immigration Act powers, of whom approximately 43% were asylum seekers. On 27 December 2008, there were 2250 people in detention centres, 70% of whom had been detained for 29 days or more (Home Office 2009). There are currently ten immigration removal centres and short-term holding facilities in the UK, three run by HM Prison Service and the remainder by private companies. There are plans to increase their holding capacity with the addition of two new sites and the expansion of the existing ones.

Asylum seekers, refugees and mental health

Asylum seekers and refugees in the UK have higher rates of mental health problems than the general population. Studies have shown increased rates of anxiety and depression (Burnett 2001), post-traumatic stress disorder (Fazel 2005) and suicide and self-harm (Cohen 2008).

Post-migration factors

In this journal, McColl *et al* (2008) have summarised the effect of pre-migration and post-migration factors on mental health. It has been recognised that it is not only pre-migration factors (such as war, torture and rape) that contribute to these conditions. Post-migration factors, including attitudes and policies of the host country, have a significant impact on the development and prognosis of mental illness. The same authors identified adversities such as discrimination, destitution and denial of healthcare as important. The College has published a position statement that highlighted the fact that current public policy can increase the likelihood of a refugee or asylum seeker developing mental health problems (Royal College of Psychiatrists 2007).

An Australian study that examined the mental health of Tamil asylum seekers compared those held in detention with those residing in the community while their applications were being processed and found more depression, panic, post-traumatic stress disorder and suicidal urges in those who were detained (Thompson 1998).

As mentioned above, a systematic review of ten studies investigating the impact of detention on the mental health of asylum seekers also found high levels of mental health problems in detainees. Particularly common were anxiety, depression, post-traumatic stress disorder and self-harm (Robjant 2009).

According to Home Office statistics, in the first half of 2008 incidents of self-harm in UK Immigration Centres rose by 73%, with 109 cases requiring medical attention. Cohen (2008) conducted a study using statistics from immigration centres, coroners' records and HM Prison Inspectorate. It showed that the suicide rate of detained asylum seekers was 112 per 100 000 for 1997–2005. This peaked at 222 per 100 000 for 2002–2004. The average suicide rate in the UK is 9 per 100 000.

Healthcare in immigration centres

According to The Detention Centre Rules 2001, their purpose is to 'provide secure but humane accommodation of detained persons in a relaxed regime with as much freedom of movement and association as possible'. They also specify that healthcare should be provided at least to the standard of the National Health Service. Healthcare in immigration centres is not provided directly through the NHS. Instead, the companies that run them employ healthcare staff and contract some services, such as out-of-hours primary care cover, to local deputising agencies. Most care is provided by qualified nurses and daily sessions from general practitioners, and some centres also have input from visiting specialists such as psychiatrists.

Monitoring standards Standards in immigration centres are monitored regularly by HM Inspectorate of Prisons and audited against The Detention Centre Rules 2001 and The Detention Centre (Amendment) Rules 2005. Concerns have been expressed about healthcare provision in many centres. For example, the 2007 unannounced inspection of Colnbrook Immigration Removal Centre found that the provision of mental healthcare had been adversely affected by staff vacancies and that rooms in the healthcare centre contained potential ligature points (HM Chief Inspector of Prisons 2007). There is no central clinical governance of the structure or process relating to healthcare provision in detention centres as this lies outside the remit of the NHS.

Ethical considerations Doctors working in these environments, like those providing services to prisons, need to consider the complex ethical issues involved in treating patients within a setting that can, by its very nature, cause or exacerbate psychological distress. The question has been raised as to whether it may in fact not be possible to provide adequate mental healthcare in such circumstances. These are similar issues to

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those faced on a daily basis by people working in prison healthcare. The Chief Inspector of Prisons stated: 'An Immigration Removal Centre is not a prison. Detainees have not been charged with a criminal offence, nor are they detained through normal judicial processes' (HM Inspectorate of Prisons 2002). However, some of those housed in these centres may experience the process as one of incarceration: 'a sense of powerlessness and isolation contributed to the despondency of some detainees' (HM Chief Inspector of Prisons 2006).

Learning from the prison service

Lessons can be learned from the experience of HM Prison Service. It was not until April 2006 that healthcare in prisons was funded and provided through primary care trusts. They are now subject to the same training and clinical governance requirements as the rest of the NHS. Prior to this there had been numerous reports about the inadequacies of the prison healthcare system (Department of Health 1999). Although far from perfect, there have been great strides made towards providing prisoners with the same standard of healthcare available to those in the community (Birmingham 2006). Given that Britain currently detains the greatest number of asylum seekers, for longer periods, than anywhere else in Europe (Bosworth 2008) and that the UK Border Agency planned 900 extra places within detention centres in 2009 (UK Border Agency 2009c: p. 11), the need for careful regulation of healthcare provision is particularly important.

Implications for forensic services

The mental health legislation described below refers to England and Wales, and there are similar provisions under the Mental Health (Care and Treatment) (Scotland) Act 2003.

Two groups of patients in forensic mental health services are particularly affected by immigration policy: those detained under the Immigration Act who are transferred to hospital under Section 48 of the Mental Health Act, and foreign nationals detained under a restricted hospital order in terms of Sections 37 and 41.

Section 48 patients

It is possible for people detained under the Immigration Act who become mentally ill while in custody to be transferred for treatment in hospital under Section 48 of the Mental Health Act 1983 and to receive treatment in the same way as a transferred prisoner. However, the complexity of this situation means that when these patients no longer require hospital treatment clinicians are faced with what might seem very difficult decisions. In such circumstances patients will be transferred back to a detention centre where appropriate medical care may be lacking. They may also face swift deportation, with inadequate health facilities being present in their own country. The clinician may believe that either of these scenarios will lead to a deterioration in their patient's mental health. This needs, however, to be balanced against the inappropriateness of continuing to detain somebody in hospital when it is no longer necessary. The issues involved are illustrated in the clinical vignette in Box 2.

> **BOX 2** Case study: the Immigration Act and Section 48 transfers
>
> A 23-year-old woman from Somalia was transferred from an immigration detention centre to a medium secure unit for treatment under Sections 48 and 49 of the Mental Health Act 1983. She was experiencing a manic episode and was becoming increasingly difficult to treat by the healthcare staff at the detention centre. She had been studying at university but had left her course when she became unwell and had not complied with the necessary arrangements to maintain her permission to be in the UK. She had therefore been taken to a detention centre to be deported. Once in hospital she responded well to treatment and her mental state stabilised. On further investigation, it became apparent that the medication to which she had responded well was not available in Somalia and there would be very few psychiatrists and no out-patient services available. It seemed inevitable that a return to her home country would result in a relapse. The patient was very concerned about returning home and now that she was better was keen to return to studying for her Masters degree.

Escalating numbers

According to the prison service, the number of foreign national prisoners has doubled in the past 10 years and this group now makes up 14% of the total prison population in England and Wales (HM Prison Service 2007). Given these figures, it is clear that there are implications for forensic mental health services that are likely to be called upon to assess and admit an increasingly large number of foreign national patients. The patient's offence may make them liable to be considered for deportation. This affects both transferred prisoners and patients who receive a restricted hospital order.

Procedural uncertainty

The situation for mentally disordered offenders under the UK Border Act 2007 is less clear than that for prisoners. Detention under certain sections

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of Part 3 of the Mental Health Act (including a Section 37 hospital order, a Section 45A hospital and limitation direction and a Section 47 transfer direction for convicted prisoners) provides exemption from automatic deportation. The UK Border Act does not clarify what will then be the likely outcome for these patients. A procedure to identify foreign nationals has been implemented but in our experience secure hospitals are not involved in this identification process or informed when their patients have been so identified.

Unlike the prison service, where the institution is involved in identifying foreign nationals, in forensic mental health services the Ministry of Justice fulfils this role for restricted patients. The Ministry passes demographic information to the UK Borders Agency for a decision on deportation. The clinical team and patient may be preparing for discharge before they are made aware that there is a question of deportation, as the UK Borders Agency does not make its decision until discharge is imminent. There does not seem to be any provision for identification of foreign national mentally disordered offenders subject to Part 3 of the Mental Health Act, apart from those under a restricted hospital order.

Section 86 repatriation

There is a procedure in place for repatriation of foreign national patients under Section 86 of the Mental Health Act ('Removal of alien patients'). This process was concisely described by Green & Nayani (2000) and applies to those detained under both Part 2 and Part 3 of the Act. It allows the Secretary of State to authorise the removal of patients without the right of abode in the UK to be repatriated to their home country if it is in the patient's best interests and a mental health tribunal agrees. The underlying principle of Section 86 is the best interests of the patient and their individual needs, whereas the emphasis of the new procedure is on the protection of society based on generalised immigration policies rather than individualised patient care. Under Section 86 repatriation, psychiatric follow-up in the receiving country has to be organised, escorting staff and appropriate transport can be arranged, and perhaps most importantly removal of the individual to their country of origin only occurs if it is judged to be in the patient's best interests.

Restricted hospital order patients

Under the new policy, patients detained under Sections 37 and 41 of the Mental Health Act may be deported when they are conditionally discharged either by a tribunal or the Secretary of State. As the decision regarding this is not made until the patient is ready for discharge, forward planning is extremely difficult. This creates issues both with treating the patient effectively and with the deportation itself. Ordinarily, the clinical team will be preparing a package of care in the community, both to ensure the stability of the patient's mental health and to reduce any risk to the public. This is difficult to do when the team will have little control over any provision of mental healthcare in the patient's home country or there remains uncertainty as to whether the patient will be deported or not. Paradoxically, the deportation decision cannot be made until the patient is ready for conditional discharge but it is not possible to prepare the patient for discharge until the decision is made. This uncertainty is likely to provoke anxiety in the patient, who often will not want to leave the UK. An example of this situation is given in Box 3.

Issues that this situation raises and that must be given due consideration in the provision of care for patients in this situation include: the variation in availability of psychiatric care and treatment between different countries; the problems inherent in attempting to arrange suitable transfer of care; the return of the patient to a potentially traumatic, or in some cases dangerous, situation; and the stress of deportation itself. In addition, it will be unclear what will happen between discharge from hospital and deportation. Will clinical teams be expected to find suitable accommodation until removal is implemented, will patients be sent to immigration removal centres or will they stay longer in secure units than may otherwise have been strictly necessary?

BOX 3 Case study: mentally disordered offenders facing deportation

A 27-year-old man was detained under Sections 37 and 41 of the Mental Health Act 1983 in a medium secure unit after attacking a work colleague while floridly psychotic. He had had no previous contact with mental health services and it appeared that he had been suffering from schizophrenia for several years. His psychosis was initially difficult to treat but he then responded well to clozapine and made good progress, with increasing periods of leave into the community. The clinical team began liaising with the Ministry of Justice to grant the patient a conditional discharge. Although the patient was from a European Union country and had been working legally in the UK for several years, as a result of his offence he was being considered for deportation. His country does not have out-patient psychiatric services and clozapine is not available.

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Conclusions

The UK is employing increasingly restrictive policies in relation to controlling immigration, including detaining immigrants in detention centres. The changing immigration policies and legislation can be difficult for clinicians to keep pace with. It is important for psychiatrists to have some understanding of changes in policy and statute as these can affect healthcare provision. Many psychiatrists will have contact with mentally disordered foreign nationals, as in-patients, out-patients or during Mental Health Act assessments. Some may provide care in immigration removal centres. At a wider level the medical profession may be required to respond to the ethical and practical issues raised. For psychiatrists, these issues may be particularly important because of the impact of migration and detention on mental health, the need for longer periods in hospital and adequate follow-up in the community. There may be conflicts between policy driven by perceived societal need and provision of individual clinical care. It might be argued that all doctors continue to have a duty of care for patients no matter what their immigration status is judged to be. As described here, this can be difficult to achieve in the current circumstances.

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MCQ answers

1	2	3	4	5
a f	a f	a f	a f	a t
b f	b f	b t	b f	b f
c f	c f	c f	c f	c f
d t	d f	d f	d t	d f
e f	e t	e f	e f	e f

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MCQs

1 The following is responsible for monitoring the standard of healthcare provided in immigration removal centres:
a primary care trusts
b NHS clinical governance
c HM Prison Inspectorate
d no one
e the UK Border Agency.

2 The approximate number of people living outside their country of birth is:
a 50 million
b 75 million
c 100 million
d 150 million
e 200 million.

3 People in a detention centre who require treatment in hospital for a mental illness can be transferred under the following Section of the Mental Health Act 1983:
a Section 2
b Sections 48/49
c Section 3
d Sections 47/49
e none.

4 The following post-migratory factor could affect mental health:
a torture in the country of origin
b the country of origin
c lack of healthcare in the country of origin
d attitudes and policies of the host country
e war in the country of origin.

5 According to HM Prison Service, the proportion of the prison population in England and Wales that comprises foreign nationals is:
a 14%
b 50%
c 2%
d 8%
e 20%.

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