RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

PS07/16

Definition of torture in the context of immigration detention policy

POSITION STATEMENT

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Introduction

Prior to 12 September 2016, it was long-standing Home Office policy that those with independent evidence that they had been tortured were accepted to be unsuitable for detention and should only be detained if a high threshold of very exceptional circumstances was met.

New policy was introduced on 12 September 2016 (Home Office, 2016*a*,*b*,*c*). This includes the following changes.

- The definition of torture is now limited to the definition in Article 1 of the UN Convention Against Torture 1987 (UNCAT) which requires that the harm in question was 'inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity'. The policy states that this 'includes such acts carried out by terrorist groups exploiting instability or civil war to hold territory'.
- Doctors are instructed that they should only make 'Rule 35(3)' reports raising concerns that the detainee may have been a victim of torture if those concerns arise from this more restrictive definition. The policy also suggests that doctors 'might find it helpful' to send a *pro forma* letter to a detainee explaining that a Rule 35(3) report has not been made because the detainee's account does not meet this definition of torture.
- In order to benefit from the strong presumption against detention, victims of torture may have to demonstrate an additional requirement of evidence that detention is likely to be injurious to health or that detention is likely to lead to a risk of significant harm.

The Royal College of Psychiatrists is concerned that the new policy will significantly weaken the existing safeguards for vulnerable people with a history of torture, trafficking or other serious ill-treatment and that it will not, as is ostensibly intended, provide better protection for vulnerable groups against their detention and from the disproportionate adverse effects of such detention on those with a history of serious traumatic experiences.

The new Home Office policy adopts the UNCAT definition of torture. It is our understanding that this was developed in the context of international law to protect individuals from being subjected to torture by the state rather than for the purposes of making individual decisions about the suitability of individuals for immigration detention and about their vulnerability to its adverse effects. It contrasts markedly with the previous policy and the ruling given by the High Court in *EO v Secretary of State* [2013], in which expert evidence from

authoritative sources was considered. The UNCAT definition was rejected in favour of a broader definition of 'torture' which focused on the severity of the harm inflicted upon the victim, rather than on the identity of the perpetrator of that harm. In reaching this conclusion, the Court placed particular weight on evidence from the late Helen Bamber OBE, 'whose experience and expertise in the field is unrivalled', and in which she 'importantly' concluded 'that there is no significant difference between the therapeutic needs of victims of torture in the UNCAT sense, or in the wider sense' (*EO v Secretary of State*, paragraph 81).

The Royal College of Psychiatrists endorses these views and confirms its agreement that the issue of state responsibility for torture does not in itself determine either the impact of the ill-treatment or the resultant therapeutic needs of the individual.

The Royal College of Psychiatrists is further of the view that the issue of state responsibility for torture is not determinative of any consequent vulnerability to the adverse effects of immigration detention.

Review of evidence relating to the impact of immigration detention on mental health

A systematic review by Robjant *et al* (2009*a*) identified ten clinical studies on the mental health of detained asylum seekers. High levels of mental health problems were reported, with anxiety, depression and post-traumatic stress disorder (PTSD) commonly reported, as well as self-harm and suicidal ideation. All the studies reviewed found high levels of emotional distress among individuals who were or had previously been in immigration detention. The distress related in part to pre-detention trauma experiences (such as torture) in addition to the independent adverse effects of detention itself.

Professor Mary Bosworth's (2016) more recent comprehensive review of the research evidence on the impact of immigration detention on mental health formed an important part of the Home Office-commissioned Independent Review into the Welfare in Detention of Vulnerable Persons by Stephen Shaw (2016).

Professor Bosworth reviewed over 30 clinical studies conducted between 1991 and 2015, from a number of different countries and with sample sizes ranging from 10 to over 700 individuals. She concluded that there was consistent evidence for a negative impact of immigration detention on the mental health of those so detained. The three predominant forms of mental disorder related to immigration detention are depression, anxiety and PTSD. The key predictors of the negative impact of detention on mental health included duration of detention, pre-existing trauma, pre-existing mental and physical health problems, and poor general and mental healthcare services in detention. Asylum-seekers with a history of torture were identified as particularly vulnerable to negative mental health outcomes in detention, as were children and women.

The evidence reviewed by Professor Bosworth showed that duration of immigration detention was closely related to mental health outcomes – the longer the individual was detained, the greater the adverse impact – as well as evidence that mental health deteriorated even after relatively short periods of detention: after just 18 days (Cleveland *et al*, 2012) and after 30 days (Robjant *et al*, 2009*b*).

Concerns regarding proposed changes following review of existing evidence

The evidence summarised above indicates that a history of torture is associated with increased vulnerability to the ill effects of immigration detention on the individual's psychological state and mental health beyond the generalised detrimental effect of such detention on detainees as a whole. There is no research evidence or clinical indication that the issue of state responsibility for torture and ill-treatment predicts vulnerability to the adverse effects of detention. Loss of agency and powerlessness is the common feature, and it is this that is critical to the consequent risk of harm if the person is again subject to constraint, rather than the identity of the agent and their relationship to the state. This can arise in a range of scenarios where individuals were deprived of their liberty or where their movements were constrained. This could be committed by state officials or by insurgent groups or militia, human traffickers, or by community or even family members. It is the experience of the individual that results in risk of harm.

An assumption that only victims of torture inflicted by public officials or other persons acting in an official capacity (or at their instigation, or with their consent or acquiescence) are vulnerable to the adverse effects of detention risks missing other no less highly vulnerable people.

We are also concerned about the requirement for clinicians carrying out assessments under Rule 35 of the 2001 Rules to determine whether a detainee's history of ill-treatment fits the complex juridical UNCAT Article 1 definition. The question of whether an act of torture is inflicted by public officials or other persons acting in an official capacity (or at their instigation or with their consent or acquiescence) is a legal rather than a clinical issue. In our view, it is not appropriate to expect medical practitioners to make such assessments and distinctions. This equally applies to the question of whether the ill-treatment was carried out by 'terrorist groups exploiting instability or civil war to hold territory'.

In addition, we are concerned about any change from practice that is based on the long-standing consensus that torture victims are not suitable for detention, and are at particular risk of the adverse effects of detention, to a new and additional obligation to establish whether

anticipated harm has occurred or is occurring. The evidence and findings summarised above show that individuals who have survived trauma, torture or ill-treatment are especially vulnerable to the harmful impacts of detention, irrespective of the issue of state responsibility for the treatment. A history of torture alone predisposes an individual to a greater risk of harm, including deterioration in mental health and increased risk of anxiety, depression and PTSD, than would be experienced in the general detained population.

Writing a letter (as suggested in the new policy) explaining that a Rule 35(3) report has not been made because the detainee's account does not meet the UNCAT definition of torture, and thereby refusing to document their ill-treatment, appears to place the doctor in direct conflict with the 'duties of a doctor' as defined by the General Medical Council (2014): the overriding duty to 'make the care of your patient your first concern'.

Any change in policy that requires medical practitioners to identify evidence of actual harm or deterioration in mental health in order for a detainee to benefit from the strong presumption against detention is in our view unacceptable.

We have considered the changes made to DSO 9/2016 on 15 November 2016 (Home Office, 2016*b*). This now provides guidance that where doctors consider that a detainee's account of torture does not fit the UNCAT definition, but nevertheless have concerns about a detainee, they should report their concerns through alternative means, such as a Rule 35(1) report. The guidance also states that where doctors are not sure whether an account fits the UNCAT definition, they should err on the side of caution and send a Rule 35(3) report, leaving the Home Office to decide whether the definition is met.

These clarifications do not address our fundamental concerns that doctors should not be expected to apply a complex juridical definition like UNCAT and that there is no evidence that shows that state responsibility for torture is determinative of whether a survivor is vulnerable to the adverse effects of immigration detention.

The Royal College of Psychiatrists is mindful of the fact that the independent Shaw Review found the safeguards, prior to the changes of 12 September 2016, to be insufficiently effective to protect vulnerable people from being detained and from suffering further harm as a result of their detention. We are concerned that the new Home Office policy does not improve on the previous policy, but further weakens the already inadequate safeguards in operation at the time of Stephen Shaw's review by adding unnecessary and inappropriate complexity that does not assist in identifying those who are particularly vulnerable to the adverse effects of detention.

We therefore recommend a return to the pre-12 September 2016 policy in so far as it provided for the broader definition of torture approved in the EO case for people with independent evidence of torture (according to that broader definition) to benefit from a strong presumption against detention except under 'very exceptional circumstances'.

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