



Faculty of Forensic & Legal Medicine

Quality Standards for healthcare professionals working with victims of torture in detention

May 2019 Review date May 2022 – check www.fflm.ac.uk for latest update

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Executive Summary

The healthcare of those in detention who have been tortured or subject to inhuman or degrading treatment has long been the subject of international interest. The Mandela rules (the UN Standard Minimum Rules for the Treatment of Prisoners), as well as guidance from the UN Istanbul Protocol, the World Medical Association and the Council of Europe, lay out the basic principles that should be applied. The Faculty of Forensic and Legal Medicine of the Royal College of Physicians (FFLM) is the government recognized standard setting institution for healthcare in police detention in the UK. In 2016 the FFLM, seeking to build on these principles, set up a working group to draft the first set of detailed quality standards for this area of healthcare. This document is the result. It addresses the specific vulnerabilities of victims of torture in detention and sets out for the healthcare professional not only what should be done, but why, how, and how we can know that it has been done.

The work has been guided additionally by the principles that:

- detention is acknowledged to be harmful to the health of victims of torture
- healthcare professional have an obligation to identify and report torture
- torture victims have a right to rehabilitation
- rehabilitation cannot be effectively undertaken whilst they are in detention

These quality standards recognize that healthcare professionals working in places of detention

- will identify victims of torture and despite reporting that fact,
- will continue to have the obligation to meet their healthcare needs insofar as it is possible to do so, until such time as they are released.

The ambition and scope of the standards is broad. They will affirm those professionals who already practice ethically, as well as providing a training framework for those new to this area of work. They will also provide support for those professionals who wish to challenge detaining authorities to improve the standards of detention healthcare. Lastly, it is hoped that they will increase the identification of torture and its resultant healthcare needs, and reduce the risk of further harm.

We therefore recommend that:

1. Healthcare professionals working in detention apply the standards to improve the healthcare of victims of torture, and if in conflict with the demands of detention authorities, use them to maintain their ethical obligations
2. All detaining officials and agencies and those commissioning or providing healthcare, or inspecting places of detention utilise and cascade the document.

Acknowledgements

The Faculty of Forensic and Legal Medicine of the Royal College of Physicians (FFLM), are grateful to the following for their work as members of the Healthcare Professionals who work with Victims of Torture (HWVT) working group, set up to produce these quality standards.

Dr Silvia Casale (Former President of UN Sub-committee on Prevention of Torture and Council of Europe Committee for the Prevention of Torture)

Sue Fewkes (The UK Association of Forensic Nurses)

Dr Hugh Grant-Peterkin (Royal College of Psychiatrists)

Kris Harris (Medical Justice)

Dr Cornelius Katona (Helen Bamber Foundation and the Royal College of Psychiatrists)

Dr Piyush Pushkar (Royal College of Psychiatrists)

Dr David Rowen (British Association for Sexual Health and HIV)

Dr Cath White (St Marys Sexual Assault Referral Centre, Manchester)

The late Dr Michael Wilks (FFLM)

The document has benefited from review by members of FFLM, survivors of torture, the Faculty of Law of Oxford University, Physicians for Human Rights, the International Rehabilitation Council for Torture Victims, Dignity Institute, the International Committee of the Red Cross, the Secure Environments Group of the Royal College of General Practitioners, NHS England, and the Ethics Committee of the British Medical Association. We are grateful to all the individuals who provided this help.

The official launch of the document on 2nd July 2019 is sponsored by Forensic Healthcare Services Ltd., and the W G Johnson Trust.

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Overview

This document provides quality standards for the recognition and management, by all healthcare professionals, of the healthcare needs of victims of torture and ill treatment in all places of detention. These quality standards address the specific vulnerabilities of this patient group. The meaning of the term healthcare professionals that applies in this document is all doctors, nurses and paramedics carrying out regulated activity, but may also be taken as guidance for other regulated healthcare professionals.

These issues commonly overlap with the healthcare needs of other vulnerable groups, so many of the principles set out in this document are applicable to other patients. The United Nations have set out general guidance on the minimum rules for the treatment of prisoners¹ and the Committee for the Prevention of Torture also sets out general standards for care of victims of torture in detention.² The World Medical Association Tokyo Declaration (last revised 2016) also addresses this issue.³ In this document we provide standards not only on **what** should be done, but **why**, **how**, and **how we can establish that it has been done**.

Detention is acknowledged to be harmful to the health^{4,5} of victims of torture. Healthcare professionals have an

obligation to identify and report torture (Nelson Mandela Rules 34¹). Torture victims have a right to rehabilitation – as set out in the UN Committee Against Torture General Comment 3 (paragraphs 11-15)⁶ and other documents.⁷ Rehabilitation cannot be effectively undertaken whilst they are in detention.⁸ Healthcare professionals working in places of detention will identify victims of torture and despite reporting the fact, will continue to have the obligation to meet their healthcare needs insofar as it is possible to do so, until such time as they are released. This is particularly important in those circumstances when the authorities may delay or find reasons to refuse their release. Healthcare professionals do not have the option of doing nothing in such cases.

1. UNODC
UN Standard Minimum Rules for the treatment of Prisoners (Nelson Mandela Rules) (accessed 08/01/2019)
2. Council of Europe
The CPT Standards (accessed 08/01/2019)
3. WMA
Tokyo Declaration of the World Medical Association 1975 (accessed 22.04.2019)
4. Royal College of Psychiatrists
Definition of torture in the context of immigration detention policy PS07/16 2016 PS07/16 2016 (accessed 13/01/2019)
5. Bosworth, M. (2016)
The Impact of Immigration Detention on Mental Health: A Literature Review
Review into the Welfare in Detention of Vulnerable Persons Cm 9186. London: HSMO. Criminal Justice, Borders and Citizenship Research Paper No. 2732892
6. UN
CAT general comment 3
7. *Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law* (Resolution adopted by the UN General Assembly on 16 December 2005) (accessed 13/01/2019)
The right to redress is also explicitly recognised in the Universal Declaration of Human Rights (Article 8), the International Covenant on Civil and Political Rights (Article 2), the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Article 14), the Additional Protocol I to the Geneva Conventions of 1949 (Article 91), the Rome Statute of the International Criminal Court (Article 68)
8. Royal College of Psychiatrists
Position Statement on detention of people with mental disorders in Immigration Removal Centres (accessed 13/01/19)



Definitions

The United Nations Convention Against Torture definition is:

'Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is 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'

However, in this document the definition that is used is that arising from EO and ORS⁹ and that is supported by the Royal College of Psychiatrists Position Statement June 2016 'Definition of torture in the context of immigration detention policy.'¹⁰ This acknowledges that similar degrees of harm may have been suffered by others who do not meet the specific UN definition:

'Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed, or intimidating or coercing him or a third person, or for any reason based upon discrimination of any kind.'

The United Nations High Commission for Refugees (UNHCR) detention guidelines 2012¹¹ recommend the phrase '*victims of torture or other serious, physical, psychological, sexual or gender-based violence or ill-treatment*'.

For the purposes of this document therefore, when reference is made to 'victims of torture' it should be assumed that the same standards should be applied to a wider clinical group of victims of serious harm, such as for example, victims of modern slavery and human trafficking.

The term 'victim' is also used to subsume the meaning of the term 'complainant' i.e. when the allegation of torture has not been proven in a court of law. For the purposes of defining quality standards, we have concluded that this differentiation is not important. We do this without prejudice to other terms, such as survivor, that may be preferred by those who have suffered harm.

It should also be taken that when the term 'patients' is used, a shift of focus from 'detainees' is not inferred, but rather that a healthcare culture is centred on patients, whether they are detainees or not.

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9. [Neutral Citation Number: \[2013\] EWHC 1236 \(Admin\)](#)
(accessed 14/01/2019)
10. Royal College of Psychiatrists
[Definition of torture in the context of immigration detention policy](#)
(accessed 08/1/2019)
11. UNHCR
[Detention Guidelines](#)
(accessed 08/01/2019)

Introduction

Why are Quality Standards needed?

Victims of torture and ill treatment may be found in all places of detention including psychiatric institutes, immigration removal centres (IRC), prisons and police stations. Their experience of torture is very likely to make them vulnerable. The effect of torture on ability to trust others, and on mental health, regularly confers on victims of torture additional vulnerability – there should be a presumption of vulnerability in all victims of torture just as there is an inherent vulnerability in all children.

Prior health conditions and the specific impact of detention processes are aggravating factors that can increase the harmful effects of torture. A review of the welfare of vulnerable persons in detention¹² has drawn attention to concerns about their complex healthcare needs.

The Faculty of Forensic and Legal Medicine of the Royal College of Physicians (FFLM), whose work focuses on the care of the vulnerable, has acknowledged expertise in setting clinical standards for police custody healthcare and sexual offence medicine. It was agreed by the Board of the FFLM that it would be appropriate, drawing also on the expertise of other clinicians and colleagues working with victims of torture, to develop clear clinical standards for healthcare practitioners who provide healthcare for victims of torture in all places of detention.

Prevalence of torture:

Estimates vary widely in different parts of the world. In the UK health care professionals are most likely to come across victims of torture in patients who are seeking asylum. It is likely that over 30% of asylum seekers,¹³ have been torture victims. A US meta-analysis suggests 44% of refugees have suffered torture.¹⁴

Clinical consequences of prior torture:

Detention of a victim of torture has an impact beyond that of the torture itself, or of detention on a different individual. These different impacts will be considered below:

- the impact of detention on health,
- the impacts of torture on health, and
- the impact of detention on torture.

12. Shaw, S. 2016
[Review into the welfare in detention of vulnerable persons](#)
(accessed 08/01/2019)

13. Kalt A, Hossain M, Kiss L, Zimmerman C.
Asylum seekers, violence and health: a systematic review of research in high-income host countries
Am J Public Health. 2013 Mar;103(3):e30-42
doi: 10.2105/AJPH.2012.301136. Epub 2013 Jan 17. Review

14. Higson-Smith C. 2016
[Updating the estimate of refugees resettled in the United States who have suffered torture](#)
(accessed 09/01/2019)



Methods of torture include:

Physical torture:

- blunt force
- sharp force
- burns
- electrical
- chemical
- extremes of heat and cold
- stress positions
- asphyxia
- drowning simulation such as water-boarding

These methods can cause a wide variety of injury including superficial or deep wounds, fractures, joint injury, nerve damage and injury to internal organs. Environmental conditions may cause sunburn, frostbite, dehydration and malnutrition. While some victims have visible scars or marks as a result of torture, such treatment commonly leaves little or no external physical evidence.

As a result, victims of torture and ill treatment may have chronic, generalized or specific pain and untreated infections. Head and traumatic brain injury may have adversely affected their cognitive function and behaviour regulation, and they may develop post-traumatic seizure activity.

Sexual torture, not uncommonly involving multiple assailants, may include:

- forced nakedness
- being forced to witness sexual violence
- sexual assault by touching or forced insertion of objects
- oral, vaginal or anal rape
- injury to the ano-genital area
- sexually transmitted infections
- forced transgression of sexual orientation and gender identity

Such events may have both physical and psychological effects on the individual. The very profound psychological effects include overwhelming feelings of shame, stigma and fear. Difficulties in disclosing experiences of sexual violence, whatever the gender of the victim, may add to the impact on the individual as they delay in accessing the treatment they need.

Psychological methods of torture include:

- solitary confinement
- sensory deprivation
- manipulation of the environment – including exposure to extremes of heat, cold, light or dark
- mock execution
- humiliation and threats
- behavioural coercion and
- forcing the victim to witness the torture of others

The effects are commonly assessed in diagnostic categories such as anxiety, depression, post traumatic stress disorder (PTSD) and psychosis. The Istanbul Protocol, the UN Manual on the Effective Investigation and Documentation of Torture and other cruel inhuman or degrading treatment or punishment,¹⁵ makes clear that not everyone who has been tortured necessarily develops a diagnosable mental illness. Behavioural change may result including social withdrawal, fearfulness, insomnia, hyper-vigilance, dissociation, paranoia, aggression, panic attacks, substance misuse, self-harming behaviour and suicidality. Victims of torture and ill treatment may suffer flashbacks or intense intrusive memories of their experiences and these may be triggered by sights, sounds and smells. In some cases, psychological effects of torture show after a long time, even years or decades later.

Detention in the UK and risks for patients' health:

Detention is potentially very disruptive to health care with pre-detention medical care being stopped abruptly, hospital appointments missed, and scheduled treatment cancelled.

Specific effects of detention on the physical health of patients, whether or not they are victims of torture and ill treatment include:

- limited access to movement and the ability to exercise outside
- poor ventilation and close confinement, which increases the risk of rapid spread of infections
- changes in diet that may lead to loss of appetite and poor nutrition

15. *Istanbul Protocol, the UN Manual on the Effective Investigation and Documentation of Torture and other cruel inhuman or degrading treatment or punishment*. UN OHCHR 2004 (accessed 09/01/2019)



Psychologically, detention can lead to:

- anxiety and depression
- over the longer term, passivity, hopelessness and despair.
- loss of self-esteem and mood changes are well recognised as consequences of immigration detention which serves administrative and not criminal justice purposes^{16,17}
- extreme fear and anxiety may also trouble immigration detainees who can be held for an unknown period while also at risk of being removed to a country where they fear for their own safety.

The trauma informed care approach is being more widely adopted by those working with people in detention and with other vulnerable groups.^{18,19} This approach acknowledges that past experiences of trauma can have deep and long-lasting effects on mental health and behaviour. The approach advocates the use of 'universal precautions' in vulnerable groups, i.e. assume that trauma has occurred and act accordingly. Key to this is to change the question when faced with for example challenging behaviour, from 'What is wrong with him/her?' to 'What has happened to him/her?' A trauma responsive service will educate staff about the effect of trauma on the brain and body, eliminate unnecessary triggers to re-traumatisation, and foster feelings of safety, collaboration and empowerment in patients.

Research for the Shaw review²⁰ concluded that the predominant forms of mental disorder (in immigration centres) were depression, anxiety and PTSD. The key predictors of negative psychological outcomes of detention include:

- duration of detention
- pre-existing trauma

16. Von Werthern M, Robjant K, Chui Z, Schon R, Ottisova L, Mason C, Katona C.
The impact of immigration detention on mental health: a systematic review
BMC Psychiatry.2018 Dec;18:382 (accessed 09/01/2019)
17. Cleveland J, Kronick R, Gros H, Rousseau C
Symbolic violence and disempowerment as factors in the adverse impact of immigration detention on adult asylum seekers' mental health
Int J Public Health. 2018 Nov; 63:1001-1008 (accessed 04/01/2019)
18. Miller N & Najavits L (2012)
Creating trauma-informed correctional care: a balance of goals and environment
European Journal of Psychotraumatology, 3:1,
DOI: 10.3402/ejpt.v3i0.17246 (accessed 09/01/2019)
19. Sweeney A, Clement S, Filson B, Kennedy A, (2016)
Trauma-informed mental healthcare in the UK: what is it and how can we further its development?
Mental Health Review Journal, Vol. 21 Issue: 3, pp.174-192
(accessed 09/01/2019)
20. Shaw, S. HMG publication (2016)
Review into the welfare in detention of vulnerable persons
(accessed 08/01/2019)

- pre-existing mental and physical health problems and
- poor healthcare services in detention

Asylum seekers with a history of torture were identified as particularly vulnerable to negative mental health outcomes.²¹

Effects of detention on victims of torture:

Specific experiences of detention may trigger powerful and traumatising memories of torture experiences. For example, the sounds of keys jangling, guards' footsteps, male voices shouting, and metal doors banging have all been identified as powerful triggers that recall both detention and torture in their country of origin.²² The faces of their torturers may be seen in the faces of the officers around them. The recall of sexual violence may be powerfully evoked by something as simple as the smell of sweat. Freedom of movement and communication is severely limited and personal control is once again usurped by all-powerful forces.

These effects not only exacerbate greatly any pre-existing mental health problems but also specifically elicit the symptoms due to their torture, thereby increasing the frequency and intensity of flashbacks, intrusive recall and nightmares, hypervigilance, irritability avoidance symptoms and withdrawal.²³

These can lead to behavioural problems (as noted above), of aggression, emotional lability, and avoidance of medical care. Such problems can then lead to punishment for breaches of regulations.²⁴

Experiences of loss of agency and powerlessness are key to the consequent risk of further harm in detention, rather than the specific identity of the perpetrators.²⁵ The extent of state responsibility for their experiences of serious harm may not be the determining factor in the impact of those experiences on their mental health, but for some victims of torture and ill treatment the effect is to make it very difficult for them to trust state officials thereafter, even in a different country.

21. Royal College of Psychiatrists
Definition of torture in the context of immigration detention policy. PS07/16 20 (accessed 13/01/2019)
22. Medical Justice 2015
A secret punishment – the misuse of segregation in immigration detention
(accessed 13/01/2019)
23. ibid
24. ibid
25. Cleveland J, Kronick R, Gros H, Rousseau C
Symbolic violence and disempowerment as factors in the adverse impact of immigration detention on adult asylum seekers' mental health
Int J Public Health. 2018 Nov; 63:1001-1008 (accessed 04/01/2019)



It can thus be difficult for healthcare professionals in the detention setting, where they are likely to be viewed by the victims of torture as agents of the state, to engage in a trusting therapeutic relationship with victims of torture, and victims of torture may specifically avoid going to healthcare while in detention as they do not trust anyone in the detention setting to help them. Further, a key feature of post traumatic stress disorder is avoidance of reminders of the trauma, which can contribute to avoidance of seeking healthcare and a general lack of help-seeking behaviour.²⁶

This establishes barriers for those offering healthcare- the victims of torture may be in need of help but will not engage, resulting in exacerbation of the condition due to lack of treatment. Maintaining positive relationships is recognized as critical to helping children- for adults who are victims of torture it is also key to achieving good healthcare outcomes.²⁷ A healthcare professional whether assessing a victim of torture as their treating clinician, or as a forensic expert writing a medico-legal report, has the same overarching duty of care to offer advice or take action if they discover unmet treatment needs.

Professional responsibility

Healthcare professionals working in detention settings have a duty²⁸ to:

- identify, document and report victims of torture and ill treatment, at the earliest opportunity
- identify their health care needs
- facilitate a trusting relationship
- respect their patient's autonomy
- respect the need for informed consent and confidentiality
- determine how best they should be treated
- report if a person is unfit for detention or for the processes required by the detaining authorities
- fulfil their ethical obligations to detained patients, retaining their independence and if there is a conflict, putting the needs of their patient above the requirements of a third party
- clearly identify their role if carrying out assessment for processes required by the detaining authority or other third party

26. Iverson A et al
Help-seeking and receipt of treatment among UK service personnel
British Journal of Psychiatry 2010. 197: 149-155

27. Dibben M, Lean M
Achieving compliance in chronic illness management: illustrations of trust relationships between physicians and nutrition clinic patients
Health Risk and Society. 2003; 5:241-258

28. See rules 24-35 of the *UN Standard Minimum Rules for the treatment of Prisoners (Nelson Mandela Rules)* UNODC 2015 (accessed 09/01/2019)

Outcomes

The aim of developing these standards is to achieve the following :

- identification, documentation and reporting of victims of torture
- improved treatment of health conditions for victims of torture and ill treatment in detention
- reduced frequency of adverse outcomes such as self-harm and suicide attempts
- improved quality of life for victims of torture and ill treatment in detention
- healthcare professionals are empowered to maintain their ethical obligations to their patient if in conflict with the requirements of the detention authorities.
- reduced vicarious traumatisation of healthcare professionals
- patients are given a positive experience of care

Ingredients for success

1. Service coordination

To deliver these outcomes reliably and safely, services need to be coordinated:

- a. within a place of detention,
- b. between places of detention when patients are moved and
- c. with and between secondary care and community care providers.

2. Information Governance

Protocols and methods should align with the General Data Protection Regulations (GDPR) and professional guidelines that address confidentiality and information sharing in health services. They should comply particularly in the specific case of requests by patients and non-health care agencies for access to health information.

3. Training and competencies

- a. All healthcare professionals involved in assessing and caring for victims of torture should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard.
- b. All healthcare professionals working in the detention setting should have sufficient and appropriate training and competencies to effectively fulfil their ethical obligations to detained patients, retain their independence and put the needs of their patient above the requirements of their employer.



Format

A template used in quality standards issued by the National Institute of Health and Care Excellence (NICE)²⁹ has been used for each of the 12 Quality Standards in this document.

There are five sections:

- Statement – the purpose of the standard is defined
- Rationale – an explanation is given of the standard
- Quality measures – the key elements of the standard
- Quality standards – the ways in which the measures are assessed
- Implications for the four main stakeholders: commissioners, service providers, healthcare professionals and service users

The virtue of this structure is its simplicity and direct application to the purpose of the standards. Some case studies are included to illustrate the clinical issues.

Index of Quality Statements

1. Identification

Detained victims of torture are identified so that torture can be reported and their healthcare needs can be met.

2. Ethical obligations

Healthcare professionals working with detained victims of torture understand their ethical obligations.

3. Consent and confidentiality

The principles of medical information management are maintained by healthcare professionals working with detained victims of torture.

4. Communication

Healthcare professionals to ensure accurate communication is facilitated for detained victims of torture in all clinical assessments for those not fluent in the primary language of the area in which they are detained, or with other communication challenges.

5. Mental Capacity

Detained victims of torture whose autonomy may be compromised receive appropriate assessment.

6. Access to healthcare

Pending release, detained victims of torture can access appropriate services or treatment equivalent to that available in the community.

7. Vicarious traumatisation

Healthcare professionals working with detained victims of torture receive support to prevent vicarious traumatisation and burnout, and promote self-care.

8. Training

Healthcare professionals who work with detained victims of torture have the required training and competence.

9. Assessment required by detention processes

Victims of torture required to go through specific detention processes receive appropriate assessment of their vulnerability.

10. Children

Healthcare professionals understand their responsibility to safeguard the wellbeing in detention of children and young people who are victims of torture.

11. Mental health

Detained victims of torture receive appropriate assessment so that their mental healthcare needs can be met.

12. Sexual violence

Detained victims of torture who have past experiences of sexual violence receive appropriate assessment so that their healthcare needs can be met.

29. NICE
Standards and Indicators

(accessed 09/01/2019)



QS1: Identification

QUALITY STATEMENT

Detained victims of torture are identified so that torture can be reported and their healthcare needs can be met

Rationale

Identification of victims of torture in detention is a requirement under the Nelson Mandela Rules – United Nations Minimum Standards for the treatment of Prisoners:

- **Rule 33 states** *The physician shall report to the prison director whenever he or she considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.*
- **Rule 34 states** *If, in the course of examining a prisoner upon admission or providing medical care to the prisoner thereafter, health-care professionals become aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment, they shall document and report such cases to the competent medical, administrative or judicial authority. Proper procedural safeguards shall be followed in order not to expose the prisoner or associated persons to foreseeable risk of harm.*
- Victims of torture are likely to have physical and psychological impact of their experiences on their health.³⁰
- These healthcare needs may not have been treated or only partially treated prior to detention, due to difficulties in accessing health care in their country of origin, during their journey to the UK and in the UK.
- Patients in detention have the right to equivalent healthcare to those in the community (Nelson Mandela Rules- United Nations Minimum Standards for the treatment of Prisoners³¹ rule 24.1).
- The process of detention may make it more difficult for them to disclose their past torture. Immigration detention, for example, can make victims of torture feel they are being treated like a criminal, and that they cannot trust anyone.

30. *Istanbul Protocol, the UN Manual on the Effective Investigation and Documentation of Torture and other cruel inhuman or degrading treatment or punishment* paragraph 234: 'torture is an extraordinary life experience capable of causing a wide range of physical and psychological suffering.'

UN OHCHR 2004 (accessed 08/01/2019)

31. UNODC 2015

UN Standard Minimum Rules for the treatment of Prisoners (Nelson Mandela Rules) (accessed 08/01/2019)

- The impact of torture itself may specifically reduce help-seeking behaviour.
- If the detaining authorities do not release the victim of torture upon receiving the doctor's report, the doctor must address their healthcare needs insofar as it is possible to do so whilst their patient remains in detention.

In order to identify, report and meet the healthcare needs of victims of torture, the healthcare professional first has to facilitate disclosure.³² Difficulty in disclosing experiences of torture is linked to the effect of torture in destroying trust in others and the powerful emotions evoked, of shame, stigma and fear. Sufficient time is needed to facilitate disclosure. Relating the experiences brings back these overwhelming and distressing feelings, as well as a fear of blame and punishment by others, especially in cases involving past experience or future risk of gender-based and sexuality-based violence by others, including family and community. There may be fears in regard to the way in which the experience of torture has threatened personal and sexual identity. Avoidance of reminders of trauma is a core feature of post-traumatic stress disorder (PTSD) and sexual violence, which is extremely common in victims of torture, and is characterized by high levels of avoidance symptoms such as efforts to avoid thoughts, feelings or discussion of the trauma.^{33,34} Silence may feel like a survivor's only way of coping.³⁵

32. *Istanbul Protocol*, paragraph 163: 'at any given time of an evaluation, situation-specific variables, such as the dynamics of the interview, feelings of powerlessness in the face of having one's intimacy intruded upon, fear of future persecution, shame about events and survivor guilt may simulate the circumstances of a torture experience. This may increase the patient's anxiety and resistance to disclose relevant information.'

33. *Istanbul Protocol, the UN Manual on the Effective Investigation and Documentation of Torture and other cruel inhuman or degrading treatment or punishment* paragraph 254
UN OHCHR 2004 (accessed 08/01/2019)

34. Bögner D, Herlihy J, Brewin CR. *Impact of sexual violence on disclosure during Home Office interviews* Br J Psychiatry. 2007 Jul;191:75-81

35. Tankink M (2006) *Silence as a means of controlling the explosive nature of sexual violence* (accessed 14/01/2019)



The Istanbul Protocol³⁶ in paragraph 147 notes the same difficulty.

'The presence of psychological sequelae in torture survivors, particularly the various manifestations of PTSD, may cause the torture survivor to fear experiencing a re-enactment of his or her torture experience during the interview, physical examination or laboratory test.'

When experiences of torture have been in a detention setting, further experiences of detention, even though in a different country, may evoke overwhelming memories of the experience and inability to trust any personnel of the detaining authorities, including the healthcare professionals.

Facilitating disclosure of torture experiences requires:

- creation of trust and rapport
- understanding of consent and confidentiality (see "QS3: Consent and confidentiality")
- use of professional interpreters if needed (see "QS4: Communication")
- consideration of the effect of gender of clinician and interpreter – patients should be offered choice in this
- adequate time
- clinical skills in full physical and psychological health assessment
- identification of indicators of past torture (see below)
- provision of suitable environment with quiet and privacy

Identification of victims of torture brings opportunities for influencing and improving their healthcare in detention particularly in relation to those conditions caused or exacerbated by the torture. The first opportunity is through the reception health screening process (for example in UK IRCs, a question about past torture is mandatory at this screening) but it is likely there will be other contacts with healthcare professionals during detention including for example, following the segregation of a person, or prior to transfer or removal by air to country of origin (see "QS9: Assessment required by detention processes").

In the Nelson Mandela Rules³⁷ rule 34 states *'If, in the course of examining a prisoner upon admission or providing medical care to the prisoner thereafter, health-care professionals become aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment, they shall document and report such cases to the competent medical, administrative or judicial authority. Proper procedural safeguards shall be followed in order not to expose the*

36. *Istanbul Protocol, the UN Manual on the Effective Investigation and Documentation of Torture and other cruel inhuman or degrading treatment or punishment*
UN OHCHR 2004 (accessed 08/01/2019)

37. UNODC 2015
UN Standard Minimum Rules for the treatment of Prisoners (Nelson Mandela Rules)
(accessed 08/01/2019)

prisoner or associated persons to foreseeable risk of harm.'

As a minimum, such a report should include:³⁸

- the circumstances of the examination
- details of the torture or ill-treatment
- all physical and psychological symptoms
- findings on physical and psychological examination
- interpretation as to the probable relationship of the findings to the alleged torture or ill-treatment
- recommendation for any necessary treatment and/or further examination

Identification of torture experiences and their impact on physical and mental health will enable the obligation to report torture to be met, and for so long as the victim of torture remains in detention, enable the delivery of effective and responsive care, including secondary referral or support from allied professionals if indicated.

A care plan should be made to:

- summarise mental health care needs
- summarise sexual health care needs
- summarise physical health care needs
- list investigations and referrals required and carried out
- outline treatment plan
- record risk assessment and any action required as a result
- specify outcome of consideration if unfit for detention, unfit to fly or for other specific detention process
- specify frequency of review for any deterioration of health if detention is maintained

Quality measures

1. Evidence of local measures to ensure people arriving in detention are asked about past experience of torture
2. Evidence that when a victim of torture has been identified, this has been reported
3. Evidence of local measures to ensure those disclosing torture are assessed for the impact it has had on their health
4. Evidence of local measures to assess for torture and its impact when healthcare professionals see patients for other process requirements such as in segregation, or consideration if unfit to fly
5. Evidence of care plan following assessment
6. Evidence of completion of care plan
7. Evidence of staff training on torture

38. *Istanbul Protocol, the UN Manual on the Effective Investigation and Documentation of Torture and other cruel inhuman or degrading treatment or punishment*
Istanbul Protocol Principles in Annex I
UN OHCHR 2004 (accessed 08/01/2019)



Quality standards

1. Patients arriving in detention are asked about past experience of torture 100%
2. Patients are offered a full examination within 24 hours of arriving in detention 100%
3. Patients disclosing torture have a report made, subject to their consent 100%
4. Patients are assessed for full physical and mental health assessment by the doctor following disclosure of torture at initial health screen 100%
5. Medical records demonstrate patients identified as victims of torture at other points in detention
6. Patients assessed for full physical and mental health assessment by the doctor following disclosure of torture later in detention 100%
7. 100% of those assessed have a care plan
8. 100% of care plans completed.

Implications

What the quality statement means for commissioners

Services are commissioned that ensure victims of torture receive appropriate health care, equivalent to that in the community, have their needs identified and are not unnecessarily harmed by detention.

What the quality statement means for service providers

Service providers ensure that healthcare professionals are trained to recognise the indicators of possible past torture and assess their healthcare needs and provide facilities which enable trained staff to ask people presenting with indicators or entering detention about their experiences and the impact on their health.

What the quality statement means for healthcare professionals

Healthcare professionals recognise indicators of possible past torture and respond appropriately in assessing impact on health and healthcare needs.

Where there is provision for the detaining authorities to reconsider if detention is appropriate, this assessment is key to triggering this process. Rehabilitation needs, and the right to rehabilitation are a further reason to request release.

What the quality statement means for service users

Victims of torture in detention have their healthcare needs identified at the earliest opportunity and appropriate care plans completed.

Where there is provision to reconsider if detention is appropriate such as in immigration detention, this assessment is key to triggering a reconsideration of the decision to detain.

Early identification of the impact of torture and any additional impact of detention on their health may help to mitigate adverse effects and help them access treatment and support. Torture survivors have a right to rehabilitation.³⁹

Annexes:

Annex 1 Indicators of past experience of torture

Annex 2 Pathway following disclosure of torture

39. *Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law* (Resolution adopted by the UN General Assembly on 16 December 2005) (accessed 13/01/2019)
The right to redress is also explicitly recognised in the Universal Declaration of Human Rights (Article 8), the International Covenant on Civil and Political Rights (Article 2), the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Article 14), the Additional Protocol I to the Geneva Conventions of 1949 (Article 91), the Rome Statute of the International Criminal Court (Article 68)



ANNEX 1

Indicators of past experience of torture

While these conditions can have other possible causes than torture, they should be explored more fully when noted:

Psychological

- Severe sleep disturbance
- Medically unexplained symptoms
- Panic attacks, faints, 'funny turns'
- Behaviour indicating mental health problems particularly relating to PTSD- anxiety, jumpiness, flashbacks, auditory or visual hallucinations, irritability and angry outbursts
- Substance abuse
- Paranoid ideation
- Dissociation
- Triggers to and content of intrusive recall, flashbacks or nightmares
- Profound personal detachment and social withdrawal or stupor
- Self-harming and suicidality
- Frequent severe headaches⁴⁰
- Cognitive difficulties, history of head injury, post-traumatic seizure
- Visual disturbance

Physical

- Scarring of unusual appearance, scarring widely distributed on the body and in unusual locations
- Chronic pain including joint pain and injury
- Gastrointestinal tract symptoms especially severe gastritis, retching, vomiting
- Hearing difficulties
- Frequent severe headaches
- Cognitive difficulties, history of head injury, post-traumatic seizure
- Visual disturbance

Sexual

- Ano-genital symptoms or injuries – direct questions may be needed to elicit disclosure, but note particularly: urinary dysfunction or incontinence, lower abdominal pain, rectal pain, bleeding, discharge or constipation, incontinence of flatus or faeces, persistent vulvovaginitis, vaginal fistula
- Injuries to intimate body parts – breasts, thighs, buttocks
- Douching with soap or disinfectant
- Menstrual disturbance
- Unplanned pregnancy

Narrative clues

- Gaps in the narrative of experiences 'and then I lost consciousness' or 'and then I escaped'
- Use of euphemisms 'became his wife' or 'they did what they wanted'

40. The last three bullet points in each of the psychological and physical lists above are duplicated because they could be indicators of both types of torture



ANNEX 2 Pathway following disclosure of torture

Opportunity for disclosure

- at initial health screen
- at medical review
- during medical assessment for detention process
- with choice of gender and interpreter



Full medical review

- physical healthcare needs
- sexual healthcare needs
- mental healthcare needs
- risk assessment for self harm and suicide



Care plan

- investigation, treatment, referral
- communicate results and plan to patient
- regular review to monitor progress or any deterioration
- consider if unfit for detention process in question, or for detention itself
- escalate concerns if institutional pressure is applied to you that may conflict with your duty to the patient



QS2: Ethical obligations

QUALITY STATEMENT

Healthcare professionals working with detained victims of torture understand their ethical obligations

Rationale

Ethical responsibilities^{41,42} are particularly relevant and sometimes critical in detention settings.

The principles of good ethical practice in healthcare^{43,44} include the requirement to:

- put your patient first
- maintain confidentiality
- maintain professional independence
- act to safeguard the wellbeing of vulnerable adults and all children and young people

A healthcare professional working with detained patients has also to meet standards that apply in this particular working environment:

- detained patients have an absolute entitlement to a standard of care equivalent to that in the local community,
- healthcare professionals must take no part in torture or ill-treatment
- adults in detention are vulnerable until shown otherwise
- a non-judgmental approach is of particular importance due to the likelihood of lowered psychological resilience
- healthcare professionals must ensure that their detention practice is evaluated in appraisal to mitigate the specific risk of being bullied into working outside their competence

'Dual role' has been used to describe those situations in which there is a third party to whom the healthcare professional has potentially conflicting contractual responsibilities.⁴⁵ If the

41. GMC

Confidentiality: disclosing information for employment, insurance and similar purposes (accessed 14/01/ 2019)

42. NMC

The Code (accessed 14/01/ 2019)

43. *Declaration of Geneva* (1948) Adopted by the General Assembly of the World Medical Association at Geneva, Switzerland, September 1948 (accessed 14/01/2019)

44. World Medical Association

International Code of Medical Ethics

Adopted by the 3rd General Assembly of the WMA, London, England, October 1949, and amended, 1968, 1983 and 2006 (accessed 14/01/2019)

45. Editorial (1993) *Three-faced practice: doctors and police custody*

interests of their employer and patient conflict, the healthcare professional must put the needs of their patient first '*They cannot be obliged by contractual or other considerations to compromise their professional independence.*'⁴⁶

Victims of torture in detention are especially vulnerable, in terms of their past experiences and the impact of those experiences on their health, so healthcare professionals working with such patients have a heightened responsibility to be mindful of these principles. They need to:

- remember their ethical obligations
- put the needs of their patient first
- identify themselves and explain the purpose of any examination or treatment
- refuse to comply with any procedures that may harm or leave detainees vulnerable to physical or psychological harm
- speak up when things go wrong, if services are unethical, abusive, inadequate or pose a potential threat to detainees' health, and
- support colleagues to do the same

These ethical principles are elaborated in the Istanbul Protocol chapter II.

In some circumstances the healthcare professional's obligation to report evidence of torture, according to international codes and ethical principles, may conflict with the detainee's decision to refuse consent, for example due to fear of further torture, or a lack of trust in a State-employed healthcare professional. In such circumstances the healthcare professional must respect the detainee's decision. They may be able to report the torture in an anonymized, aggregated form so long as this does not place an individual at risk and where there is an independent body that will conduct a prompt and impartial investigation. If unsure as to which is the greater harm – not reporting torture so that others may continue to be at risk, or breaching patient confidentiality and risking the health of the individual – the World Medical Association suggests

The Lancet Vol 341:May 15, 1993 pp 1245 – 1247

46. Istanbul Protocol, the UN Manual on the Effective Investigation and Documentation of Torture and other cruel inhuman or degrading treatment or punishment. UN OHCHR 2004



they should seek expert advice. They should also inform the detainee of their right to seek a clinical evaluation by a healthcare professional who is not a State-employee.

Healthcare professionals need to know how to escalate any concerns⁴⁷ about patient care in the detained environment to the healthcare centre management, their employer, their local safeguarding lead, medical defence organisation, and regulatory bodies. Where escalation of concern does not lead to the change required, the healthcare professional may need to utilise a whistleblowing policy. A whistleblowing policy needs to be understood and incorporated into practice to be effective.^{48,49}

Quality measures

1. Transparency – healthcare professionals must
 - a. identify themselves to patients
 - b. explain the purpose of any examination- whether solely for health assessment or also required for detention process
 - c. offer a chaperone if appropriate
 - d. offer the patient a copy of the consent form
2. Independence
 - a. They must ensure that their contractual terms allow them professional independence.
3. Equivalence of care
 - a. Healthcare professionals must raise concerns if the organisation fails to provide healthcare equivalent to that in the community.
4. Safeguarding
 - a. Where the patient is a minor, age-disputed minor or a vulnerable adult, healthcare professionals must be prepared to act as an advocate, by following local safeguarding procedures.
5. Information sharing (see “[QS3: Consent and confidentiality](#)”)
 - a. Patient data should not normally be disclosed without the patient’s knowledge and informed consent

- b. In exceptional cases, healthcare professionals may disclose appropriate information without consent, if non-disclosure would result in death or serious harm to the detainee or others, for example
 - acting in the best interests of a patient lacking mental capacity
 - if compelled by law to do so, to prevent a serious crime or serious public health risk
 - c. Patient data must be shared with the patient, or their authorised legal representative, if requested by the patient to do so
6. Non-participation
- a. They must refuse to comply with any procedures that may harm patients (see “[QS9: Assessment required by detention processes](#)”)
 - b. They should resist unethical requests for example to find patients ‘fit for’ detention when they are in need of healthcare only available in the community, or ‘fit for’ flight travel or transfer to another place of detention when it is contraindicated by their medical condition.
 - c. They should not participate in unethical practice including torture, providing the means of torture, force-feeding and inappropriate healthcare isolation (e.g. HIV cases).
7. Critical challenge
- a. healthcare professionals have a duty to monitor and speak out using the statutory protection for employees (Public Interest Disclosure Act 1998)
 - b. healthcare professionals have a duty to escalate concerns about health of their patients and follow up the outcome of this process

Quality standards

1. Consent forms
 - a. demonstrate that the limits of confidentiality have been explained to the patient 100%
 - b. demonstrate that consent for sharing information was sought 100%
 - c. demonstrate that consent responses have been recorded 100%
 - d. demonstrate that patients are offered a copy of the consent form 100%
2. Records demonstrate that chaperones are offered 100%
3. Healthcare professionals’ employment arrangements demonstrate full independence from the detaining authority 100%
4. Healthcare professionals demonstrate awareness of process for escalation of concerns internally and externally, and staff whistleblowing policy

47. BMA
[Guidance for consultants on raising concerns in a system under pressure](#) (accessed 14/01/2019)

48. NHS Employers
[Whistleblowing for a healthy practice](#) (accessed 08/01/2019)

49. GMC
[GMC policy on whistleblowing](#) (accessed 09/01/2019)



5. Healthcare professional records such as a significant events log demonstrate 100% effective escalation of concerns about any aspects of the health and welfare of their patients including
 - a. access to equivalent primary and secondary healthcare
 - b. provision of interpreting services
 - c. deterioration of health conditions in detention
 - d. unfitness for detention or detention processes
6. Healthcare professional records demonstrate appropriate safeguarding responses for any vulnerable child or adult 100%
7. Healthcare professional records demonstrate information sharing that is compliant with the consent that has been provided 100%
8. Where information has been shared without consent, because of the need to manage risk or legal requirements, records demonstrate clear reasoning for so doing
9. Healthcare professional records demonstrate non-participation in harmful processes or procedures 100%

Implications

What the quality statement means for healthcare commissioners:

Healthcare commissioners are commissioning healthcare for victims of torture that is fully independent of the detention authorities and equivalent to that available in the community.

What the quality statement means for service providers:

Service providers must be aware of the potential pressure from third parties on healthcare professionals and ensure that they are fully supported in professional independence and ethical practice.

What the quality statement means for healthcare professionals:

Healthcare professionals are supported in their professional practice to practise ethically and resist potential pressures from third parties.

What the quality statement means for service users:

Service users receive care equivalent to that outside detention, by healthcare professionals who maintain confidentiality, promote their health and protect them from harm.



QS3: Consent and confidentiality

QUALITY STATEMENT

The principles of medical information management are maintained by healthcare professionals working with detained victims of torture

Rationale

Detention and being a victim of torture bring additional concerns to the core health care principles of seeking informed consent and maintaining confidentiality

The General Medical Council in the UK requires doctors to:⁵⁰

- ‘Respect patient’s right to confidentiality’
- ‘Give patients the information they want or need in a way they can understand’
- ‘Respect patients’ right to reach decisions with you about their treatment and care’

The Nelson Mandela Rules – United Nations Minimum Standards for the treatment of Prisoners⁵¹ rule 32.1states:

The relationship between the physician or other health-care professionals and the prisoners shall be governed by the same ethical and professional standards as those applicable to patients in the community, in particular:

- The duty of protecting prisoners’ physical and mental health and the prevention and treatment of disease on the basis of clinical grounds only
- Adherence to prisoners’ autonomy with regard to their own health and informed consent in the doctor-patient relationship
- The confidentiality of medical information, unless maintaining such confidentiality would result in a real and imminent threat to the patient or to others
- An absolute prohibition on engaging, actively or passively, in acts that may constitute torture or other cruel, inhuman or degrading treatment or punishment, including medical or scientific experimentation that may be detrimental to a prisoner’s health, such as the removal of a prisoner’s cells, body tissues or organs

Consent may be consent for:

- examination
- further investigation or treatment
- disclosure of medical information to a third party, thus requiring exploration of ideas and expectations of confidentiality

Principles of informed consent:

- Patients have a right to withhold consent, apart from in exceptional circumstances for example where there is a risk of harm to themselves or others, for example in cases of infectious disease where others are at risk, or where they lack mental capacity.⁵²
- Doctors have a duty to give patients full information in a language and form they can understand, about the nature, purpose and risks of the process in question (see “[QS4: Communication](#)”) and including informing the patient if they have a mandatory reporting requirement.
- Doctors should give patients sufficient time to understand the information and make their decision, check whether patients have understood the information given, and whether or not they would like more information before making a decision. Patients must therefore have the mental capacity to consent to the issue in question (see “[QS5: Mental capacity](#)”).
- Patients should be informed that they can change their mind about a decision regarding consent and confidentiality at any time.
- Patients must be assured that the information being shared:
 - will not be used beyond the current agreed purpose and
 - will be stored appropriately and for no longer than is necessary for that purpose⁵³

Consent to share information must be specific and identify with whom it will be shared. If the identified individual or organization changes then specific consent must be sought again.

50. GMC

The duties of a doctor registered with the General Medical Council (accessed 09/01/2019)

51. UNODC 2015

UN Standard Minimum Rules for the treatment of Prisoners (Nelson Mandela Rules) (accessed 08/01/2019)

52. *Information sharing and suicide prevention consensus statement* 2014 (accessed 19.04.2019)

53. Home Office

The Protection, Use and Sharing of Medical Information Relating to People Detained Under Immigration Powers (accessed 09/01/2019)



Patients in detention are more vulnerable due to loss of choice in healthcare and loss of autonomy more generally. Prolonged detention can increase passivity and hopelessness, making patients less able to be proactive in exercising their rights to make choices about consent and confidentiality.

If a patient lacks capacity, the doctor must consider if disclosure will be of overall benefit to their health.

Patients with mental health conditions or cognitive difficulties may have impairment of their mental capacity to give consent for specific processes (see “[QS5: Mental capacity](#)”).

Confidentiality concerns

Victims of torture are further vulnerable in relation to the specific effects of torture. Since they are, by definition, harmed by State agents, they might lose trust in authority figures and in the responsibility of the State to care for them, and to keep their information private (see “[QS1: Identification](#)”). Their experience may be that doctors in their past have been complicit in torture, or they may fear that the doctor is obliged to report torture to the State authorities, so anything they say is not confidential.

Non-clinical purpose of sharing patient’s information

The purpose of consent to share information needs to be properly understood by the healthcare professional and the patient; consent is not always sought for the patient’s healthcare, but for a detention process such as the examination to identify if they are unfit to fly, or it may be linked to their legal position (see “[QS2: Ethical obligations](#)”). In asylum cases, information from immigration detention healthcare about medical conditions, previous treatment and even non-clinical information such as sexual orientation may be used as part of the overall assessment of credibility in the case, and any discrepancies may be highlighted as evidence of a lack of credibility. Consent should always be sought before such disclosure, and the information shared should be the minimum necessary to achieve the intended purpose and shared on a strictly need to know basis.

Healthcare professionals have a duty to report torture to higher authorities, but if the patient does not consent to the report due to fear of reprisals or other negative consequences the healthcare professionals must put their patient first. They may be able to report the torture in an anonymized, aggregated form so long as this does not place an individual at risk and where there is an independent body that will conduct a prompt and impartial investigation.

Quality measures

1. Patient assessments are undertaken where detention staff cannot hear, and preferably cannot see the consultation
2. Medical record keeping conforms to national healthcare standards regarding confidentiality and storage of personal data
3. Interpreting services are used when seeking consent from patients lacking good fluency in the local language (see “[QS4: Communication](#)”)
4. Patients are informed when they have the right to withhold consent
5. Patients are informed they can change their mind about a decision to consent or not at any time
6. The healthcare professional considers mental capacity for the specific issue to be consented
7. Consent is sought only for specific, as opposed to all purpose, reasons
8. The patient understands what information would be shared and that it would be limited to the specific purpose and not shared more widely
9. If a patient lacks capacity, information can be disclosed if it is of overall benefit to them
10. Appropriate (for emergency care of the patient or reporting of torture, or for the genuine general good) breaches of confidentiality must be recorded in the patient’s medical records

Quality standards

1. Medical records show that the consultation was out of hearing of detention staff
2. Medical records show if the consultation was in sight of detention staff
3. Medical records show that, where appropriate, a chaperone was offered, and confidentiality was maintained if accepted
4. Consent declarations show that there were no concerns on behalf of the patient about communication with the clinician
5. Consent declarations show a copy was made available to the patient
6. Consent declarations show that the patient had capacity for the decision to be made
7. Consent declarations show that the patient has been informed that they have the right to withhold consent
8. Consent declarations specify that the patient has the right to change their mind about consent at any time



9. Consent declarations specify the purpose of the decision
10. Consent declarations specify what information is to be shared and with whom
11. Consent declarations specify how and for how long the information shared will be stored
12. Medical records show that when confidentiality was breached, the reasoning behind the breach was documented

Implications

What the quality statement means for commissioners:

High quality healthcare is commissioned conforming to national healthcare standards and healthcare professionals' ethical obligations.

What the quality statement means for service providers:

Service providers conform with national healthcare standards and ensure health care professionals can follow their professional and ethical obligations.

What the quality statement means for health care professionals:

Health care professionals conform to their professional and ethical obligations.

What the quality statement means for service users:

Service users are enabled to maintain their autonomy and have confidence in confidentiality of their medical information.



QS4: Communication

QUALITY STATEMENT

Ensure accurate communication is facilitated for detained victims of torture in all clinical assessments not fluent in the primary language of the area in which they are detained, or for those with other communication challenges

Rationale

When a patient has a communication difficulty, in either speaking, understanding or hearing, their healthcare may be compromised. Serious consequences such as misdiagnosis, inadequate or wrong treatment or ineffective interventions may result.

In the specific context of vulnerable victims of torture, effective and accurate communication is required for full disclosure and assessment of their health care needs.

British Sign Language (BSL) is UK specific and a deaf person from another country may use a different sign language for which a specialist interpreter would be needed as well as a spoken interpreter to translate onward into English.

A failure to use an interpreter or the use of an inadequately trained interpreter poses risks for both patient and the healthcare provider. Untrained interpreters such as detention staff members or other detainees, (even if a friend of the patient present at their request), should not be used except in the case of a medical emergency. Untrained interpreters risk compromising both the accuracy of communication, and medical confidentiality. Family members may have a different agenda than the individual and the risk of 'honour-based' violence must be kept in mind. For victims of torture there can be a heightened anxiety about confidentiality and fear of an unprofessional interpreter spreading gossip in their community.

Standards relating to high quality interpreting and translation services for patients in the NHS⁵⁴ are applicable also in the detention setting, in order to maintain the principle of equivalence of health care.⁵⁵

Interpreters must be registered with an appropriate regulator^{56,57} (see supporting information below) to ensure ethical standards, the principles of medical confidentiality and safeguarding responsibilities are all understood

Quality measures

1. Communication difficulties:
 - a. should be identified at the time of their arrival in detention
 - b. should be managed appropriately throughout their time in detention.
 - c. should be supported by an interpreter of the patients' choice of gender
 - d. should be provided in timely fashion
2. Interpreting service failures must be reported by healthcare professionals
3. Healthcare professionals do not see patients who need an interpreter, without one (unless exceptional circumstances pertain)
4. Healthcare professionals only work with interpreters who have the required registration
5. Healthcare professionals escalate concern if interpreters do not have the required registration

54. NHS England

Principles for high quality interpreting and translation services
(accessed 09/01/2019)

55. NHS England

Principles for high quality interpreting and translation services
(accessed 09/01/2019)

56. NRPSI

Code of Professional Conduct (accessed 12/01/2019)

57. NRCPD

Code of conduct for Communication Professionals
(accessed 12/01/2019)



Quality standards

1. Healthcare professionals' reception records demonstrate communication difficulties screening 100%
2. Healthcare professionals' records demonstrate that when need for an interpreter is identified, the patient's preference of language is noted 100%
3. Healthcare professionals' records demonstrate that when need for an interpreter is identified, the patient's preference of interpreter gender is noted 100%.
4. Healthcare professionals' consultations with patients who need interpreting services are carried out with such services 100%
5. Healthcare professionals' records demonstrate that delays of greater than 48 hours (unless exceptional circumstances pertain) beyond usual waiting time for non-urgent appointments when booking suitable interpreter are noted 100%
6. Healthcare professionals' records demonstrate evidence of escalation of concern when interpreting services are not adequate in terms of:
 - availability
 - competence
 - registration

Implications

What the quality statement means for commissioners:

Commissioners are assured that victims of torture in detention receive the appropriate level of interpreting services.

What the quality statement means for service providers:

Service providers conform with NHS standards to provide quality services and ensure communication is clear and accurate.

What the quality statement means for health care professionals:

Healthcare professionals use appropriate services to ensure communication with patients is clear and accurate.

Healthcare professionals do not use untrained or unregulated interpreters (except in a medical emergency).

What the quality statement means for service users:

Service users are enabled to have accurate, effective and timely communication with healthcare professionals regardless of their primary language or any communication difficulty, by providers who are appropriately trained and regulated.

Service users are confident their medical information remains confidential.



QS5: Mental capacity

QUALITY STATEMENT

Detained victims of torture whose autonomy may be compromised receive appropriate assessment

Rationale

Two conditions are ordinarily required for a decision to be regarded as autonomous. The individual has to be free from external constraints, such as coercion, and have internal mental capacity.

The healthcare professional will need to be vigilant to ensure that they recognize external constraints, and report them when they are of concern.

In particular, the constraints may not be understood by the detainee, but will be comprehensible to the healthcare professional.

In such circumstances, the obligation to report is as pressing as if the detainee had described the constraints for himself.

The presence of a mental health disorder does not of itself mean that a person lacks mental capacity to make their own decisions, but may raise concerns. There should be a presumption that an individual has mental capacity but the prevalence of mental and physical health disorders and head injuries, affecting cognition amongst victims of torture, does lead to concern about the decision-making capacity in this patient group. Relevant mental health disorders include:

- mood disorders such as depression and PTSD
- psychotic symptoms
- cognitive deficits arising from post-head injuries
- intellectual disability

The determination that an individual has capacity is based on being able to fulfil the 4 requirements of:⁵⁸

- understanding the information relevant to the decision
- retaining that information
- weighing up the information
- communicating the decision effectively

All of these steps may be affected by the pathologies outlined:

- mood and psychotic disorders are more likely to affect the ability to weigh and balance information⁵⁹
- cognitive deficits are more likely to affect an individual's ability to understand and retain the relevant information.

Victims of torture are more likely than comparable members of the general population to have deficits in all areas of decision-making capacity, and the reasons why such deficits are not recognised include:

- an unrecognised language barrier
- absence of an interpreter
- fluctuations in decision making capacity arising from the patient's condition
- lack of continuity of care
- behaviour arising from mental disorders being misconstrued as attention-seeking⁶⁰
- healthcare professionals working outside their scope of training and competence

Consequently, the need for assessment of capacity may not be recognised and/or may not be appropriately thorough.

In the UK, an assessment of an over 15-year-old patient's capacity always starts from the position of assuming that the patient has decision making capacity with regard to the decision under review.⁶¹

Signs and symptoms of mental health disorders and/or intellectual disability in victims of torture should always lead to an assessment of the individual's decision-making capacity. If the patient does not speak the local language fluently, a trained independent interpreter must be used.

59. Owen, G.S., Szmukler, G., Richardson, G., David, A.S., Raymont, V., Freyenhagen, F., Martin, W. and Hotopf, M., 2013
Decision-making capacity for treatment in psychiatric and medical In-patients: cross – sectional, comparative study
The British Journal of Psychiatry, 203(6), pp.461 - 467

60. Review into the welfare in detention of vulnerable persons
Stephen Shaw 2016 p22 and Grant – Peterkin, H., Pickles, H. and Katona, C., 2016
Mental capacity of those in immigration detention in the UK.
Medicine, Science and the Law, 56 (4), pp.285-292

61. MCA 2005

58. Department for Constitutional Affairs, 2007
Mental capacity act 2005: code of practice
HM Stationery Office



A capacity assessment may be needed in any of the following contexts:

- to make decisions about a medical assessment/examination
- to make decisions about medical treatment
- to give consent for disclosure of medical records
- in cases of food and fluid refusal

In relation to legal processes a capacity assessment is needed:

- to instruct a solicitor
- to be interviewed
- to give evidence
- to be cross-examined

Decision making capacity is dynamic and time and decision specific. For instance, the capacity of a patient who is refusing food and fluid may initially be in place but may not continue as the impact on their health of food and fluid refusal progresses. As a second example: the decision to instruct a lawyer requires a different capacity assessment to giving evidence in court.

Protest issues and mental health problems are not mutually exclusive and so the motivation(s) of a victim of torture to refuse food and fluid must be explored and documented in detail when assessing the decision-making capacity.⁶² More than one capacity assessment may be required over a short period of time because decision making capacity is neither absolute nor irreversible.⁶³

Healthcare professionals need training in their national legislation. In the UK this is the Mental Capacity Act and the Mental Health Act. They will also need to know how to proceed when a patient is found to lack decision making capacity.⁶⁴

62. Detailed guidance on the overall management of food and fluid refusal in detained settings is available at [Guidelines for the clinical management of people refusing food in immigration removal centres and prisons](#)

63. [Guidelines for the clinical management of people refusing food in immigration removal centres and prisons](#)

64. *MCA code of practice* chapter 5
And here on page six for standards expected of healthcare providers in relation to mental capacity

Quality measures

1. Screening tool (see Appendix)

This must encompass the following:

- Assumption that capacity is always present
- Clarity about which decision is being assessed
- Does the person have an impairment or disturbance in the functioning of their mind or brain?

Having made every effort to:

- reduce or eradicate a cause of mental incapacity and
- communicate with the patient in such a way as they can best understand the information

consider does this patient still have an impairment that means they

- cannot understand the information relevant to the decision or
- is unable to retain that information or
- is unable to use or weigh up that information as part of the process of making the decision

2. Training

Healthcare professionals who encounter patients who may be engaged in decisions listed above must be trained as described above.

3. Equivalence of care

Capacity assessments must

- mirror best practice in community hospitals wherein assessments of decision-making capacity are incorporated into all healthcare decisions as a part of shared decision making.
- be specifically considered in those with
 - a. a history of, or suspected of having, any disorder of mind or brain,
 - b. those who have been victims or torture and
 - c. those who display a change in their behaviour.

4. Named capacity lead

It is good practice for every place of detention to have such a lead who should not be employed by the overall provider or the institution itself.



Quality Standards

1. Medical records demonstrate the use of a proforma (hard copy or digital) for assessing Mental Capacity 100%
2. Healthcare professionals can evidence that every capacity record is audited to demonstrate the percentage of patients found to lack capacity 100%
3. Healthcare professionals can evidence that records of patients who have been found to be victims of torture or who have been receiving care for a mental health disorder are audited to ascertain whether their decision-making capacity has been assessed

Implications

What the quality statement means for commissioners:

Commissioners are assured that services safeguard vulnerable adults.

What the quality statement means for service providers:

Assurance that appropriate assessment and care pathways, and audits for those lacking capacity, including provision of Deprivation of Liberty Safeguards and Independent Mental Capacity Advocate, are being provided.

Assurance that an appropriate training program is in place.

What the quality statement means for health care professionals:

Good team-working and communication is evidenced.

Confidence that good practice is being followed regarding mental capacity and process of assessing, documenting and subsequent care.

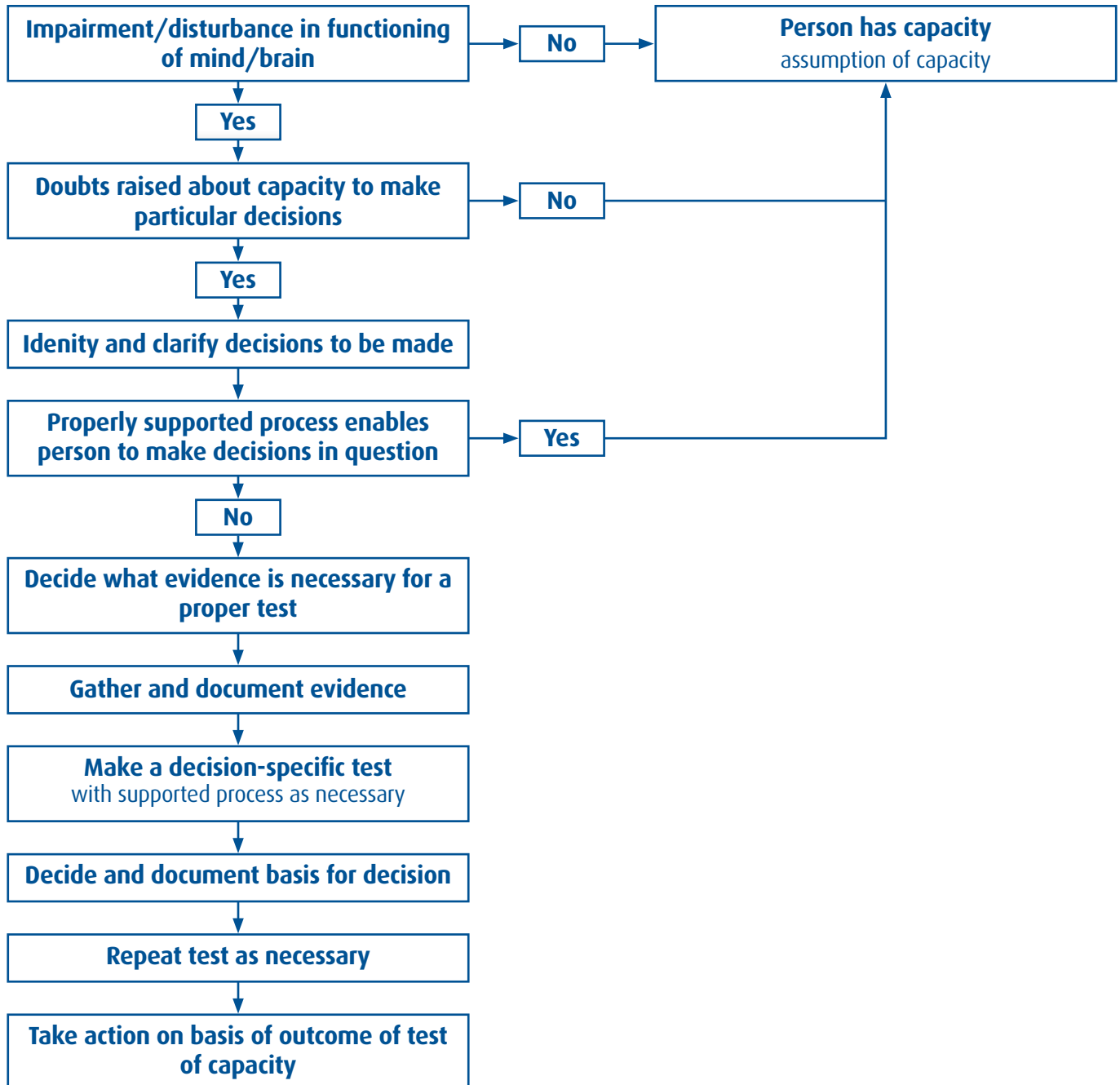
What the quality statement means for service users:

The existence of a clinical environment which

- includes reference to an individual's capacity as integral to clinical care.
- robustly investigates any possible lack of capacity in an individual but also assumes capacity to be present at the outset. Healthcare professionals successfully monitor their own performance.
- Sufficient information regarding mental capacity is given to patients in detention who are victims of torture.



APPENDIX Flow chart for assessing capacity⁶⁵



65. Church, Michael, and Sarah Watts
'Assessment of mental capacity: a flow chart guide'
The Psychiatrist 31.8 (2007): 304-307



Example proforma for assessing capacity

ly Assessment Form - LOONG, MELISSA

3/1/2018 17:30 By: Grant-Peterkin

Mental Capacity Act Assessment

Does person have Disturbance of Mind/Brain Yes No Details of disturbance

The decision to which the MCA assessment relates

<input type="checkbox"/> Consent to admission	<input type="checkbox"/> Instruct Lasting Power of Attorney
<input type="checkbox"/> Consent to treatment(s)	<input type="checkbox"/> Care needs on discharge
<input type="checkbox"/> Consent to disclosure for safeguarding purposes	<input type="checkbox"/> Discharge Destination
<input type="checkbox"/> Self-discharge against Medical Recommendations	<input type="checkbox"/> Other:
<input type="checkbox"/> Manage personal finances	

Details about the decision

For practical guidance on the Mental Capacity Act, please refer to the Code of Practice

How was the person supported to understand the relevant information

Tahoma 9

(e.g. support provided by SLT/consultation with Psychologist/Psychiatrist, information provided in simple, straightforward language supported with written material or visual aids, consideration was given to the timing and location of the assessment)

Understands Information relevant to decision <input type="radio"/> Yes <input type="radio"/> No	Evidence for this opinion Tahoma 9	Able to retain Information long enough to make a decision <input type="radio"/> Yes <input type="radio"/> No	Evidence for this opinion Tahoma 9
Able to weigh up Information (Pros & Cons) <input type="radio"/> Yes <input type="radio"/> No	Evidence for this opinion Tahoma 9	Able to communicate decision <input type="radio"/> Yes <input type="radio"/> No	Evidence for this opinion Tahoma 9

Does the patient have capacity Yes No

Is this a direct result of disturbance of Mind/Brain Yes No

Evidence for this opinion

(If the lack of capacity is not a direct result of the disturbance, please seek a second opinion)

Responsible Consultant Assessor

Plan

<input type="checkbox"/> No Further Action	<input type="checkbox"/> Second Opinion	<input type="checkbox"/> Referral for an IMCA	<input type="checkbox"/> Other:
<input type="checkbox"/> Re-assessment with lead assessor	<input type="checkbox"/> Best Interest Decision	<input type="checkbox"/> Consider whether DoLS is required	

In Progress 17:30 03/07/

Source – Homerton University Hospital NHS Foundation Trust
Author – Dr C Beale MRCPsych



QS6: Access to healthcare

QUALITY STATEMENT

Pending release, detained victims of torture can access appropriate services or treatment equivalent to that available in the community

Rationale

Victims of torture have a right to rehabilitation without delay, which is not achievable in detention. For the period that they are in detention, victims of torture are entitled to equivalent services and treatment as are available in the community.

Those who are managerially responsible for places of detention owe a duty of care with regard to the health of their detainees that they must fulfil for any individual or group, including victims of torture.

Being detained may contribute to a deterioration in mental health for victims of torture and trigger past trauma for them. The impact is

- exacerbated the longer such detention continues
- worse for those with pre-existing trauma and
- likely to persist long after detention is ended⁶⁶

The Royal College of Psychiatrists Working Group on Asylum Seekers and Refugees specifies that:

*'[t]reatment of mental illness requires a holistic approach and continuity of care; it is not just the treatment of an episode of mental ill health but an ongoing therapeutic input focussing on recovery, and relapse prevention. Success of the treatment is dependent on the development of therapeutic relationships, providing a multi-disciplinary and multi-agency intervention, and using biopsychosocial model of therapeutic intervention. Management of the complex conditions that are often present in asylum seekers may also require more specific specialist therapeutic interventions that may not be routinely available in detention. Crucially, a background context of basic physical and emotional security, including an assurance of safety and freedom from harm, is a key factor in recovery from most if not all mental illness. Many cases will not even be able to engage in specialist psychological treatment without this.'*⁶⁷

Healthcare professionals may need to consider whether the

66. Bosworth, M. (2016)

The Impact of Immigration Detention on Mental Health: A Literature Review. Review into the Welfare in Detention of Vulnerable Persons, Cm 9186. London: HSMO. Criminal Justice, Borders and Citizenship Research Paper No. 2732892

67. Royal College of Psychiatrists

Position Statement on detention of people with mental disorders in Immigration Removal Centres (accessed 13/01/19)

detention environment is suitable for the required therapeutic interventions or whether they will need to consider other options in the best interest of their patient, including advocating for their release.

The more complex a patient's care needs are, the greater the need for therapeutic intervention. This increase of healthcare function increases the potential for conflict between the health and security provision because of the real or perceived (managerial) security risk of patients being moved to healthcare facilities either within the place of detention or outside it. The specific needs that have to be met will include:

- access to structured substance misuse and alcohol treatment (including acute detoxification)
- mental health in-reach
- on-site dentistry
- blood-borne virus screening
- sexual health assessments
- immunisations
- suicide prevention
- emergency care

These services are all necessary provisions in places of detention. It is less well recognised that groups such as victims of torture may have different needs that include their identification and specific support.

Like all detainees, victims of torture must have their specific healthcare needs identified. They are likely to need help to access treatment, because torture reduces the ability to form trusting relationships with authority figures. This manifests as the following:

- Non-attendance at healthcare which needs to be followed up.
- Institutional neglect of conditions that victims of torture have or that have been left untreated for long periods due to difficulty in accessing health care
 - during detention in the country of torture
 - the journey to the UK and
 - while living in difficult circumstances in the UK



Continuity of care must be maintained by notifying detention authorities of hospital or other appointments so that patients are not moved to another place of detention until the care episode is completed, and by transfer of medical records on leaving detention.

Victims of torture are often subject to frequent changes of address making continuity of medical care more challenging. This can be met by providing on release:

- handheld summaries of their medical records
- follow-up care plans and
- adequate medication or other supplies or means of access to prescription medication

The requirement to provide^{68,69} equivalent care requires partnership working between the healthcare professionals and security authorities. Whenever possible, this should be supplemented by integration with community services. Multidisciplinary, integrative working is the optimum way for achieving equivalent care and managing the relevant risks.

A fundamental point of good practice for healthcare professionals in places of detention is the maintenance of patient confidentiality. Systems of communication between healthcare partners must be resistant to scrutiny by detention officials.

All detained persons are entitled to be attended by a medical practitioner of their choice. Such a medical practitioner should expect to be offered reasonable time and facilities for examining the patient. This provision is also relevant for clinicians who are asked to assess victims of torture or ill-treatment to provide forensic evidence of torture.

It should also not be forgotten that a victim of torture may find it easier to disclose experiences of torture and health care needs to an independent doctor. The independent doctor may elicit more and different disclosure of torture because they are perceived as more distinct from the detention authorities than the doctor working in the detention facility. Access to such doctors should be supported by healthcare professionals and information about healthcare needs should be shared, subject to consent.

Quality Measures

1. Access to services equivalent to those in the community
2. Continuity of care whilst in detention
3. Continuity of care following release from detention
4. Effective reporting mechanisms for alerting detaining authority to victims of torture in places of detention

5. Clear pathways for advocating for the release of victims of torture inappropriately detained
6. Monitoring of health for deterioration in detention

Quality Standards

1. Healthcare professionals can evidence escalation of concern where scheduled outpatient appointments are missed due to lack of escort staff or patient being moved
2. Healthcare professionals can evidence non-removal to another place of detention for victims of torture awaiting further secondary care
3. Healthcare professionals can demonstrate that of those disclosing torture 100% receive a full physical and psychological examination and care plan
4. Healthcare professionals can demonstrate that of those disclosing torture 100% are reported to the detaining authorities regarding appropriateness of detention
5. Healthcare professionals can demonstrate that of those disclosing torture, 100% are reassessed at least weekly for deterioration of their health in detention
6. Healthcare professionals can demonstrate that of those disclosing torture, non-attendance at healthcare for any scheduled appointment is followed up by a personal contact by healthcare staff 100%
7. Medical records of released victims of torture demonstrate provision of a release care plan including rehabilitation needs
8. Medical records of released victims of torture demonstrate transfer of medical records
9. Medical records of released victims of torture demonstrate that discharge documentation includes details of nearest primary care to new address
10. Medical records of released victims of torture demonstrate that discharge documentation includes information to the patient on their conditions, results of any investigations, further investigations or outpatient appointments scheduled and current treatment plan
11. Medical records of released victims of torture demonstrate that discharge care documentation includes provision for access to prescriptions
12. Healthcare professionals can evidence process for shared communication where independent doctors have assessed a victim of torture

68. Council of Europe 2015
Standards and tools (accessed 09/01/2019)

69. Royal College of General Practice 2018
Prison health is public health – RCGP launches new position statement on care in secure environments (accessed 14/01/2019)



Implications

What the quality statement means for healthcare commissioner:

Assurance that victims of torture do not suffer further harm in detention.

Assurance that healthcare services are equivalent to those available in the community.

What the quality statement means for healthcare providers:

Provide equivalent services to those available in the community.

Prevent victims of torture being further harmed by detention.

What the quality statement means for healthcare professionals:

They meet their professional obligations to protect victims of torture from further harm in detention, and to refer to others to, or provide themselves, equivalent care to that available in the community.

What the quality statement means for service users:

They are not further harmed by detention.

All healthcare provision is equivalent to that available in the community.



QS7: Vicarious traumatisation

QUALITY STATEMENT

Healthcare professionals working with detained victims of torture receive support to prevent vicarious traumatisation and burnout, and promote self-care

Rationale

Healthcare professionals working in places of detention with victims of torture need to be aware of the impact of this on them and receive support to prevent adverse health outcomes and promote self-care.

Vicarious trauma is:

- a type of work-related stress that affects professionals who work with patients who have been traumatised
- the cumulative effect of contact with survivors of violence or disaster or people who are struggling
- responsible for changes in psychological, physical, and spiritual well-being
- a consequence of feeling committed and responsible to help and at times, when we are unable to fulfil that commitment
- described as feeling burdened, overwhelmed, and hopeless in the face of great need and suffering
- a catalyst to extend beyond what is reasonable for our own well-being or the best long-term interests of patients
- able to negatively affect work, colleagues, the overall functioning of the organization, and the quality of care being provided to patients

Vicarious trauma is considered unavoidable by some, the natural consequence of being human, connecting to and caring about patients as we see the effects of trauma on their lives.

Hearing about the traumatic experiences of others, and witnessing their distress, can affect the health care professional's ability to empathise and to make objective decisions. and may bring up memories of one's own past trauma.

Signs of being affected that may be observed include:

- loss of confidence or feeling lack of competence
- indecisiveness
- over involvement and difficulty managing the boundary of self and others
- loss of hope
- pessimism
- cynicism

- detachment
- cutting people off
- difficulty in managing emotions especially anger, irritability and sadness
- impatience
- missing deadlines
- increased sickness absence
- not taking all holiday allowance
- self-harming behaviour and suicidality

An unconscious defence may be to divert discussion onto less distressing topics, distance oneself emotionally or express denial or disbelief.

The effects can be summarised as falling into the categories of:

- secondary trauma- developing depression and PTSD
- saviour syndrome⁷⁰ – 'only I can help these desperate people'
- burned-out cynic⁷¹ – 'they're all lying'

The risk of developing vicarious trauma is increased:⁷²

- where people work in relative isolation or with a lack of opportunities to debrief with peers
- where workload is high with deadlines and targets to meet
- where training is insufficient for the professional demands of the work

Healthcare professionals' strategies to minimise these effects include:

- maintaining a healthy work/life balance
- taking holiday, training and study leave entitlements
- using peer support and opportunities to debrief with colleagues, especially after a crisis situation or emergency.

70. Istanbul Protocol paragraph 272 c

71. BMA

Vicarious trauma – signs and strategies for coping
accessed 09/01/2019)

72. Finklestein M, Stein E, Greene T, Bronstein I, Solomon Z;
Posttraumatic Stress Disorder and Vicarious Trauma in Mental Health Professionals, Health & Social Work, Vol 40:2, 1 May 2015, Pages e25-e31,
accessed 14/01/2019)



Managers and lead clinicians should:

- review workload of staff and minimise lone working
- facilitate complex case meetings and significant event analysis
- facilitate a work culture where staff feel able to debrief and share difficulties with each other
- ensure all staff know about options for support including peer support and occupational health support⁷³

Employers have a duty of care for their staff and health care professionals have a duty of care to their patients, to be aware of the impact of their work on them and to maintain their own health to care in order to provide best care for their patients. Healthcare professionals also need to be aware of, and act upon, symptoms in colleagues.⁷⁴

Burnout is often mentioned in connection with vicarious trauma. It presents as feelings of exhaustion, depersonalisation or cynicism towards people and work, and a sense of professional inefficiency. It has clearly been linked in medical settings to patient safety concerns and suboptimal patient care. Recognition of burnout is important because of how it can affect the care of victims of torture. The development of cynicism leads to a failure to care properly for vulnerable patients as well as to care for yourself.

Quality measures

1. Healthcare professionals are fully trained for the requirements of their role
2. Healthcare professionals take their full training and holiday entitlements
3. Multidisciplinary complex case and significant event meetings are held
4. Peer support meetings are held regularly
5. Healthcare professionals are aware of occupational health support services and external sources of support
6. Managers regularly review workload and lone working during supervision meetings
7. Health care professional demonstrate the ability to recognise any vicarious traumas symptoms affecting themselves or their peers

73. See for example in UK: *Doctors' Support Network* (accessed 14/01/2019)

NHS Practitioner Health Programme, Supporting Health of Professionals (accessed 09/01/2019)

RCN: *Member Support Services* (accessed 14/01/2019)

74. GMC

Raising and acting on concerns about patient safety (accessed 09/01/2019)

Quality standards

1. Healthcare professionals receive required training and experience 80%
2. Healthcare professionals attend mandatory peer review/ continuing professional development and supervision 100%
3. Healthcare professionals' evidence regular multi-disciplinary team meetings 100%
4. Healthcare professionals demonstrate understanding of procedures to escalate concerns 100%
5. Healthcare professionals demonstrate 100% awareness of available support networks

Implications

What the quality statement means for health commissioners:

Commission services that can provide awareness of and protection against vicarious traumatisation.

What the quality statement means for service providers:

Service providers ensure lone working is minimised, staff are appropriately trained and resourced for their roles, take their full training and leave entitlements and can and will escalate concerns as required.

Service providers promote a culture of honesty, integrity and openness.

Service providers inform healthcare professionals about peer to peer support, and other support networks including both occupational health and external agencies.

What the quality statement means for healthcare professionals:

Health care Professionals maintain their own health in order to provide best care for their patients; seeking support when needed.

What the quality statement means for service users:

Service users are provided with high quality care by health care professionals who are well supported.



QS8: Training

QUALITY STATEMENT

Healthcare professionals who work with detained victims of torture have the required training and competence

Rationale

The GMC⁷⁵ states that doctors

- must 'recognise and work within the limits of your competence'
- must regularly take part in activities that maintain and develop their competence and performance
- should be willing to find and take part in structured support opportunities offered by their employer or contracting body (for example, mentoring)
- should do this when they join an organisation and whenever your role changes significantly throughout their career
- must be familiar with guidelines and developments that affect their work

'When you do not provide your patients' care yourself, for example when you are off duty, or you delegate the care of a patient to a colleague, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient'. Nurses and paramedics are required to uphold similar standards.^{76,77}

The UN's Istanbul Protocol reminds all healthcare professionals working with victims of torture and ill treatment 'the fundamental duty always to act in the best interests of the patient, regardless of other constraints, pressures or contractual obligations'⁷⁸ and that in secure settings 'medical, including psychiatric services, must be available...without discrimination'⁷⁹

Doctors and other healthcare professionals need training and competency in

- recognition and management of their ethical obligation to patients in detention (see "[QS2: Ethical obligations](#)")
 - maintenance of professional independence
 - ability to act as an advocate
 - safeguarding vulnerable patients
 - whistleblowing when needed,
 - specific health conditions and needs of victims of torture (see "[QS1: Identification](#)", "[QS10: Children](#)", "[QS11: Mental health](#)", "[QS12: Sexual violence](#)")
- awareness of the demands of the work on oneself and need for self-care (see "[QS7: Vicarious traumatisation](#)")
- additional concerns about confidentiality in this patient group (see "[QS3: Consent and confidentiality](#)")
- additional concerns about mental capacity in this patient group (see "[QS5: Mental capacity](#)")
- working with interpreters (see "[QS4: Communication](#)")

Employers have a responsibility to ensure that their staff have the required experience, training and competency to deliver healthcare to this vulnerable patient group, with equivalence to that available in the community and mindful of the additional ethical obligations for staff in the detained setting.

If staff do not have all of the required competencies at the start of their employment, employers must provide induction procedures to cover those additional areas. Where temporary staff are employed, the same requirements must be upheld.

Training should be by an appropriately qualified provider who works regularly in a clinical setting, and is not employed by the detention authority.

75. GMC
[The duties of a doctor registered with the General Medical Council](#) (accessed 14/01/2019)

76. NMC
[The Code](#) (accessed 09/01/2019)

77. HCPC
[paramedics](#) (accessed 09/01/2019)

78. [Istanbul Protocol, the UN Manual on the Effective Investigation and Documentation of Torture and other cruel inhuman or degrading treatment or punishment](#) paragraph 66
UN OHCHR 2004 (accessed 08/01/2019)

79. [Istanbul Protocol](#) paragraph 52
UN OHCHR 2004 (accessed 08/01/2019)



Trauma-Informed Care^{80,81,82} is being increasingly recognised as an effective set of principles to adopt in assisting healthcare professionals in their practice when working with those who have suffered past trauma and adverse childhood experiences. Healthcare professionals working in detention with victims of torture may find the application of these principles helpful and benefit from training for themselves and non-clinical staff. Training aims to reduce triggers to retraumatisation, helping people to identify their triggers, use grounding and de-escalation techniques. Trauma informed care emphasises safety, trust, choice, collaboration and empowerment.

Quality Measures

1. Healthcare Professionals undergo initial training course on commencement of this work to include:
 - a. verbal and non-verbal communication (use of simple direct communication to facilitate understanding)
 - b. working with interpreters
 - c. safeguarding vulnerable adults and children
 - d. awareness of Indicators of Torture / ill treatment/ vulnerability red flags
 - e. sexual assault awareness
 - f. sexual health screening
 - g. assessment of mental capacity and knowledge of mental capacity legislation
 - h. seeking informed consent and maintaining confidentiality
 - i. identification of barriers to travel/fly
 - j. assessment of health conditions making a person unfit for detention processes including segregation, continued detention, being interviewed, air travel
 - k. risk assessment for harm to self and others
 - l. documentation of injuries
 - m. training in trauma informed care or equivalent
 - n. whistleblowing policy
2. New and temporary healthcare professional staff are given support and supervision if they have not completed training.

80. Nursing Times
Trauma-informed care in response to adverse childhood experiences
(accessed 09/01/2019)

81. Miller N & Najavits L (2012)
Creating trauma-informed correctional care: a balance of goals and environment, European Journal of Psychotraumatology, 3:1,
DOI: 10.3402/ejpt.v3i0.17246 (accessed 09/01/2019)

82. Sweeney A, Clement S, Filson B, Kennedy A, (2016)
Trauma-informed mental healthcare in the UK: what is it and how can we further its development?
Mental Health Review Journal, Vol. 21 Issue: 3, pp.174-192
(accessed 09/01/2019)

Quality Standards

1. Demonstrate 100% of staff complete training in all of the above within 6 months of starting post
2. Demonstrate supervision processes for new, locum and temporary staff pending their completion of training

Implications

What the quality statement means for health care commissioners:

Health care commissioners commission services meeting the required standards of competency and training to provide healthcare that meets the needs of this vulnerable group.

What the quality statement means for service providers:

Service providers employ healthcare professionals with required training and experience and provide support and training for shortfalls in knowledge and practice.

What the quality statement means for healthcare professionals:

Healthcare professionals are appropriately trained and competent to care for victims of torture in detention.

What the quality statement means for service-users:

Service users have their health care needs effectively identified and treated by trained and competent healthcare professionals.



QS9: Assessment required by detention processes

QUALITY STATEMENT

Victims of torture who are required to go through specific detention processes receive appropriate assessment of their vulnerability

Rationale

Detention authorities may seek clinical assessment of a person's fitness to undergo various detention processes. The list of such processes begins with 'fitness for continued detention' and includes 'fitness to fly' assessment prior to removal to their home country, 'fitness to travel' within the country, use of control and restraint techniques and 'fitness for continued segregation'. A healthcare professional may also be required to assess if a person is 'fit for' an interview process.

Ethical guidance directs a doctor to consider specifically if a person has any medical condition that makes them unfit for the process in question, since it is not ethical for a doctor to participate in or sanction any procedure that may cause a patient harm.

The UN Office of the High Commissioner for Human Rights states that it is a contravention of medical ethics for doctors to:

'...certify, or to participate in the certification of, the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health...'

For a victim of torture this includes any processes that may harm their mental health – such as detention, segregation, control and restraint techniques. It also includes the process of being returned to their country of origin, particularly if that carries a risk of either victimisation or further torture.

The Nelson Mandela Rules⁸³ also requires the doctor to ensure patients are protected from harm in detention:

Rule 33 – The physician shall report to the prison director whenever he or she considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.

Rule 34 – If, in the course of examining a prisoner upon admission or providing medical care to the prisoner thereafter, health-care professionals become aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment, they shall document and report such cases to the competent medical, administrative or judicial authority. Proper procedural safeguards shall be followed in order not to expose the prisoner or associated persons to foreseeable risk of harm.

There are both clinical and ethical issues to be considered by the health care professionals whose role requires their participation in these processes. It is unethical to find a detainee 'fit for' a process that is likely to harm them, but it is also unethical for a health care professional not to assess the health of a person under their care, particularly if their health is likely to be further harmed. The health care professional has a duty to report their concerns. The Nelson Mandela Rule 46 clarifies:

1. Health-care personnel shall not have any role in the imposition of disciplinary sanctions or other restrictive measures. They shall, however, pay particular attention to the health of prisoners held under any form of involuntary separation, including by visiting such prisoners on a daily basis and providing prompt medical assistance and treatment at the request of such prisoners or prison staff.
2. Health-care personnel shall report to the prison director, without delay, any adverse effect of disciplinary sanctions or other restrictive measures on the physical or mental health of a prisoner subjected to such sanctions or measures and shall advise the director if they consider it necessary to terminate or alter them for physical or mental health reasons.
3. Health-care personnel shall have the authority to review and recommend changes to the involuntary separation of a prisoner in order to ensure that such separation does not exacerbate the medical condition or mental or physical disability of the prisoner.

83. UNODC 2015

UN Standard Minimum Rules for the treatment of Prisoners (Nelson Mandela Rules) (accessed 08/01/2019)



The health care professional should consider how past torture may:

1. **have contributed to the need for the process**, due to its effects on mental and physical health, which in turn may lead to incongruent behaviour and difficulty in fitting in with detention procedures.
2. **increase the risk of harm resulting from the process**, which may consequently trigger re-experiencing symptoms. This may be related to any number of situations individual to the person's past experience of torture and is not confined to, the following:
 - sight of uniformed officers, batons, handcuffs, and keys
 - sounds of heavy boots, banging doors, rattling keys, and shouting
 - being shut in a small cell or room
 - being looked at through observation slits in a door
 - witnessing aggression or violence between other detainees
 - perceiving control and restraint techniques as echoes of physical torture methods
 - experiencing segregation as reliving past solitary confinement
 - being held in restraints

leading to a deterioration in their mental health and potentially giving rise to or increasing the risk of self-harm and suicide.

Solitary confinement is well known to have highly adverse impact on mental health and wellbeing, including causing or exacerbating anxiety, depression, cognitive disturbances, paranoia, hallucinations and psychosis. Segregation may be so close to a person's previous experience of solitary confinement that they cannot distinguish it from what happened to them before. Evidence also suggests that self-harm and suicide are more common in solitary confinement compared to the general prison population⁸⁴ and segregation should not be imposed on those who are being monitored for self-harm unless there are exceptional circumstances.⁸⁵ The Istanbul expert statement on solitary confinement states, as do the Mandela Rules, that 'the use of solitary confinement should be absolutely prohibited in the following circumstances:

- for death row and life-sentenced prisoners by virtue of their sentence,
- for mentally ill prisoners, and
- for children under the age of 18'.⁸⁶

Victims of torture are more likely to have mental health problems and thus more likely to be adversely affected by segregation. They may have had past experience of solitary confinement. Doctors need to be aware of this when making an assessment of harm from continued segregation.

Case study

A 25-year old man was reported behaving in a disruptive manner, shouting and gesticulating wildly. He refused to return to his room. Officers were called and attempted to move him towards his room. He resisted. Control and restraint methods were used and he was forcibly removed to segregation. He was assessed by the doctor who found him to be unwilling to speak more than a few words but found no reason he was unfit for segregation. Two hours later the doctor was recalled to segregation to find he had extensive bruising and abrasions to his forehead where he had been banging his head against the wall and was highly agitated, responding to auditory hallucinations and looking terrified. The psychotic episode proved long lasting and required a two-week inpatient stay in a psychiatric hospital. Later he was able to describe how he had seen the officers who had tortured him coming all around him and when he was restrained and put in segregation he was convinced they were taking him to be killed. If the doctor had known of the patient's past experiences of torture including prolonged solitary confinement, they could have found him unfit for segregation.

Earlier identification and treatment of his severe PTSD would be likely to have led to a more favourable mental health outcome.

84. Shalev S (2008) A sourcebook on solitary confinement Mannheim Centre for Criminology, The London School of Economics: London. 15-16.

85. Shalev S, Edgar K. (2015) *Deep Custody: Segregation units and close supervision centres in England and Wales* Prison Reform Trust (accessed 09/01/2019)

86. *Istanbul Statement on the use and effects of solitary confinement* 2007 (accessed 09/01/2019)



Clinical assessment

Full physical and mental health assessments are required to establish if the patient is unfit to be detained or unfit for other detention processes.

Disclosure of past experiences of torture (see “[QS1: Identification](#)”) will inform the healthcare professional about clinical conditions the patient may be suffering from and which may be affected by the specific process in question.

Factors that further affect disclosure include:

- physical injury as a result of torture
- untreated infectious disease
- chronic pain
- mental health symptoms linked to torture, particularly PTSD
- consequential sense of powerlessness, manifesting as a loss of agency

The presence of an interpreter to facilitate adequate clinical assessment, especially when mental health assessment is required, is vital (see “[QS11: Mental health](#)”).

Physical evidence of torture may be found such as scars, deformities, or neurological deficit but many forms of torture leave little or no lasting physical evidence, yet have severe psychological impact.

Ethical considerations

Healthcare professionals – patient relationships

- Health care professionals may be seen by their patient as colluding with the detention authorities if the healthcare professionals take part in these assessments. A perception that the healthcare professional is closer to the detaining authorities than to the patient will affect the healthcare professional- patient relationship and also damage the trust the healthcare professional should encourage their patient to place in them.

- The healthcare professional should clearly communicate to their patient the purpose of any assessment that is primarily for processes required by the detaining authority rather than for their healthcare needs.

Institutional influences

Health care professionals can experience institutional pressure:

- to comply with these processes
- to limit the time available to make their assessments
- to conduct assessments in the presence of detention officers instead of in a confidential setting
- to not find patients unfit for the process required

Healthcare professionals must be familiar with the local escalation policy to deal with such situations (see “[QS2: Ethical obligations](#)”).

Patient autonomy

It is important that the healthcare professional is confident about their patient’s capacity to make the choices offered below.

Particularly if there is no perceived therapeutic benefit for them, the patient may refuse to:

- sign consent for sharing medical information
- undergo an examination
- undergo tests
- undergo treatment
- eat and drink – (food and fluid refusal/‘hunger strike’)

Health care professionals need to know what action to take in such circumstances.

The healthcare professional needs to ascertain the person has mental capacity to make these decision (see “[QS5: Mental capacity](#)”). They may need to carry out a mental health assessment.

Case study

A patient with poorly controlled blood pressure was examined to see if he was ‘fit to fly’. His blood pressure was mostly recorded as above the Civil Aviation Authority (CAA) limits but his compliance with medication was reported to be poor. The doctor felt that if he took the medication his blood pressure could be sufficiently controlled to make him fit to fly. Some staff alleged that he was refusing to take the medication deliberately to evade deportation. How should the doctor proceed?

The doctor should carefully explain to the patient the reasons their blood pressure needs to be well-controlled and the risk they are taking with their health in taking medication erratically. The doctor should ensure that the patient understands the information given, using an interpreter if needed and that they have mental capacity to decide whether or not to follow the doctor’s medical advice to take the medication prescribed. In the event a capacitous patient refuses to take the medication prescribed and as a result their blood pressure is uncontrolled and therefore makes them unfit to fly according to CAA rules the doctor has no other option than to certify them unfit to fly and must resist any institutional pressure to do otherwise.



Detention processes

1. Unfitness for continued detention:

Release from detention may be necessary on health grounds. This applies if:

- the patient's health makes them unfit for detention, or
- their health likely to be made significantly worse by detention or
- their health condition cannot be treated in detention on a basis of equivalence to care available in the community

Detention is not a good therapeutic environment, limiting treatment options.⁸⁷ **Rehabilitation for torture victims is not possible in detention.**

It is recognised that detention can make the mental health worse of those who are the victims of torture,⁸⁸ exacerbating their symptoms and retraumatising them. This needs to be taken into consideration when determining whether someone is unfit for **continued** detention.

- ### 2. Segregation
- also known as 'removal from association' or solitary confinement, (also temporary confinement, care and separation, isolation, closer monitoring cell, close supervision centre) requires a medical assessment within two hours of the person entering segregation and daily thereafter, to assess whether their health is being adversely affected by the continued segregation. Segregation may be used to 'punish' disruptive behaviour without assessing the cause of that behaviour.⁸⁹ A full mental health assessment is key. Segregation will be highly likely to make their mental health worse.⁹⁰ They may also suffer from suicidal thoughts and impulses and if the detainee's mental health deteriorates in segregation there is a risk of escalating self-harm and suicidal behaviour.

Doctors have a duty to raise the concern that a person should not be segregated if they consider the detainee's health is being harmed or is at risk of serious harm by solitary confinement, and to escalate their concern if solitary confinement is maintained despite their concern being expressed.

The World Health Organization states that:

*'...doctors should not collude in moves to segregate or restrict the movement of prisoners except on purely medical grounds, and they should not certify a prisoner as being fit for disciplinary isolation or any other form of punishment'*⁹¹

The Nelson Mandela Rules 45.2 state: *'The imposition of solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures...'*

Rule 46 states: *'Health-care personnel shall not have any role in the imposition of disciplinary sanctions or other restrictive measures. They shall, however, pay particular attention to the health of prisoners held under any form of involuntary separation, including by visiting such prisoners on a daily basis and providing prompt medical assistance and treatment at the request of such prisoners or prison staff. 2. Health-care personnel shall report to the prison director, without delay, any adverse effect of disciplinary sanctions or other restrictive measures on the physical or mental health of a prisoner subjected to such sanctions or measures and shall advise the director if they consider it necessary to terminate or alter them for physical or mental health reasons. 3. Health-care personnel shall have the authority to review and recommend changes to the involuntary separation of a prisoner in order to ensure that such separation does not exacerbate the medical condition or mental or physical disability of the prisoner.'*

- ### 3. Movement
- around the country from one place of detention to another can have profound psychological impact on the patient and impact on their access to continuity of healthcare. Outpatient appointments and follow up care may be missed, or results of tests not given, leading to anxiety and failure to treat conditions or unnecessary repetition of investigations. Movement may take the person far from their family and friends leading to loss of their support from visits. The health care professional may be able to place a 'medical hold' on a patient to limit their movement while medical treatment of a condition is completed.

87. Royal College of Psychiatrists

Position statement on detention of people with mental disorders in immigration removal centres (accessed 14/01/2019)

88. Bosworth, M. (2016)

The Impact of Immigration Detention on Mental Health: A Literature Review
Review into the Welfare in Detention of Vulnerable Persons, Cm 9186. London: HSMO. Criminal Justice, Borders and Citizenship Research Paper No. 2732892

89. Medical Justice 2015

A secret punishment – the misuse of segregation in immigration detention (accessed 09/01/2019)

90. Shalev S (2008)

A sourcebook on solitary confinement
Mannheim Centre for Criminology, The London School of Economics: London (accessed 13/01/2019)

91. World Health Organization

Health in Prisons: A WHO Guide to the Essentials in Prison Health
Regional Office for Europe (accessed 09/01/2019)



4. Use of control and restraint techniques during movement and removal or at other times in detention may be inappropriate. The healthcare professional has a role in advising on when it is inappropriate to use them or would be harmful to their patient's health.⁹² For a victim of torture, use of control and restraint techniques may immediately trigger frightening recall of their past torture experiences. There should be a presumption against use of handcuffs during treatment or consultation. Security staff should be out of earshot to maintain patient confidentiality. Safeguards against risk of violence to the patient themselves or others or risk of absconding should be commensurate with actual risk and balanced with the risk of harm to the patient by the anxiety caused and their right to privacy, and the harm to the therapeutic relationship between the patient and the health professional.

5. Unfitness to fly. Victims of torture should have their physical and psychological conditions assessed in keeping with the general Civil Aviation Authority (CAA) guidelines.⁹³ A victim of torture facing return to the country where that torture took place may be extremely distressed during removal and may attempt to resist the process, leading escort staff to use control and restraint measures, so the health care professional should also consider the implications of this in their assessment and the risk of asphyxia and other injury to their patient.⁹⁴ If an attempt to remove fails, the person must be given an immediate medical examination on return to the detention centre to record any harm suffered during the removal attempt. In their paper on fitness to fly in those being forcibly removed or deported from the UK,⁹⁵ Pickles and Hartree further comment that 'fitness to fly' should always be assessed rather than assumed, and that this assessment in an unwilling passenger may raise ethical issues for the person making the assessment. These ethical issues must be resolved in accordance with the best interests of the patient.

6. Unfitness for interview. Asylum application or other interviews may require the victim of torture to answer many detailed questions. Interviews may last for several

hours. They need to be able to concentrate sufficiently to understand the process as explained to them, comprehend the questions asked, recall the details asked for and respond coherently. Victims of torture may struggle with this process and many (particularly where experiences involved sexual torture) report suffering high levels of intrusive recall of their traumatic experiences and flashbacks, which interfere with their ability to respond to the questions asked.⁹⁶

A victim of torture may understand the basic purpose of the interview and express the wish to have the process over with, hoping to expedite their release from detention. They may however be unable to take into consideration the impact of their traumatic past experiences. The doctor has a responsibility to act in the best interests of their patient, to consider the clinical elements that may compromise their ability to be interviewed, advise on the basis of their objective viewpoint and escalate concerns to the appropriate authorities if their advice is not heeded.

The doctor must not act to make the person fit for purposes of the state, but may, for example, enable the person to be considered as a vulnerable witness and treated as such.

See also Annex 5 – Assessment required by detention processes pathway

Quality measures

1. The doctor must undertake a full physical and mental health review of symptoms and current health care needs on their first contact with their patient
2. Consideration of unfitness for **continued** detention is made on first and subsequent contacts
3. Subsequent healthcare reviews should be made to assess if conditions are being made worse by **continued** detention
4. Disclosure of past experience of torture should be facilitated at each assessment as full disclosure is not usually made in the first instance
5. Health care professionals are mindful of institutional pressures during examination for detention processes
6. Consideration is made of patient's mental capacity to consent or withhold consent to the process in question
7. Healthcare professionals escalate concern if their recommendations are not followed

92. Pickles H, Norton E, Ginn E & Schleicher T
Physical restraint and the protection of the human rights of immigration detainees in hospitals
Clinical Medicine 2015 Vol 15, No 4: 334–6 334 © Royal College of Physicians
(accessed 09/01/2019)

93. Civil Aviation Authority
Assessing fitness to fly. Guidance for health professionals
(accessed 09/01/2019)

94. Council for Prevention of Torture
Deportation of foreign nationals by air
2003 (accessed 09/01/2019)

95. Pickles H, Hartree N (2017)
Fitness to fly in those being forcibly removed or deported from the UK
J Forensic Leg Med. 2017 Apr;47:55-58.

96. Bogner D, Herlihy J, Brewin C (2007)
Impact of sexual violence on disclosure during home office interviews
British Journal of Psychiatry, 191, 75-81



Quality standards

1. Medical records demonstrate any past experiences of serious harm and their effect on health
2. Medical records document reassessment of condition to consider if made worse by continuing detention
3. Health care professionals can identify how to escalate concerns if their recommendations are overruled, for example to their manager, NHS England, local Safeguarding lead, to their medical defence organisation, national Medical Association or General Medical Council, NMC or CQC (see “QS2: Ethical obligations”)
4. Healthcare professionals’ records such as a significant events log demonstrate 100% effective escalation of concerns about any aspects of the health and welfare of their patients including
 - a. access to equivalent primary and secondary healthcare
 - b. provision of interpreting services
 - c. deterioration of health conditions in detention
 - d. unfitness for **continued** detention or detention processes
5. Medical records demonstrate that examination for assessment of unfitness for process is carried out:
 - a. with informed consent
 - b. in confidence without detention staff present
 - c. with interpreter if needed
 - d. with consideration of mental capacity for the process or decision in question
 - e. with adequate time for full assessment
 - f. with planned review for any change in patient’s condition
 - g. with clear statement if patient is found unfit
 - h. with documented escalation of concern if recommendation is not met, and outcome of escalation of concern
6. **Segregation**

Medical records document:

 - a. review of past experiences of segregation and solitary confinement
 - b. daily review of mental health, symptom frequency and severity to assess for deterioration
 - c. daily risk assessment for self-harm and suicide
 - d. escalation of concern if recommendation to release from continued segregation is not followed, when detainee has mental illness, is at risk of self-harming or there is exacerbation of another health condition
7. **Control and restraint**

Medical records document:

 - a. review of past experiences of control and restraint
 - b. review of current mental health
 - c. escalation of concern if recommendation not to use control and restraint is not followed

8. Movement

Medical records document:

- a. review of the impact of control and restraint during movement, if proposed by detention authority
- b. review of current health conditions and their investigation or treatment in case movement will disrupt this
- c. review of mental health and impact of current support from family and friends which may be lost if moved
- d. escalation of concern if recommendation for use of a ‘medical hold’ is not followed

9. Unfitness to fly

Medical records document:

- a. review of mental and physical health conditions with special reference to those listed by the CAA as making a person unfit to fly
- b. considerations as above for movement regarding continuity of health care and for use of control and restraint measures during flight
- c. escalation of concern if recommendation of unfitness for flying is not followed

10. Unfitness for interview

Medical records document:

- a. review of mental and physical health conditions with special reference to effects on memory and concentration
- b. escalation of concern if recommendation of unfitness for interview is not followed

Implications

What the quality statement means for commissioners:

Healthcare commissioners commission adequately resourced and healthcare services managed independently from the detention authorities.

What the quality statement means for service providers:

Service providers ensure healthcare professionals can follow their professional and ethical obligations, to meet the healthcare needs of their patients and protect them from harm.

What the quality statement means for healthcare professionals:

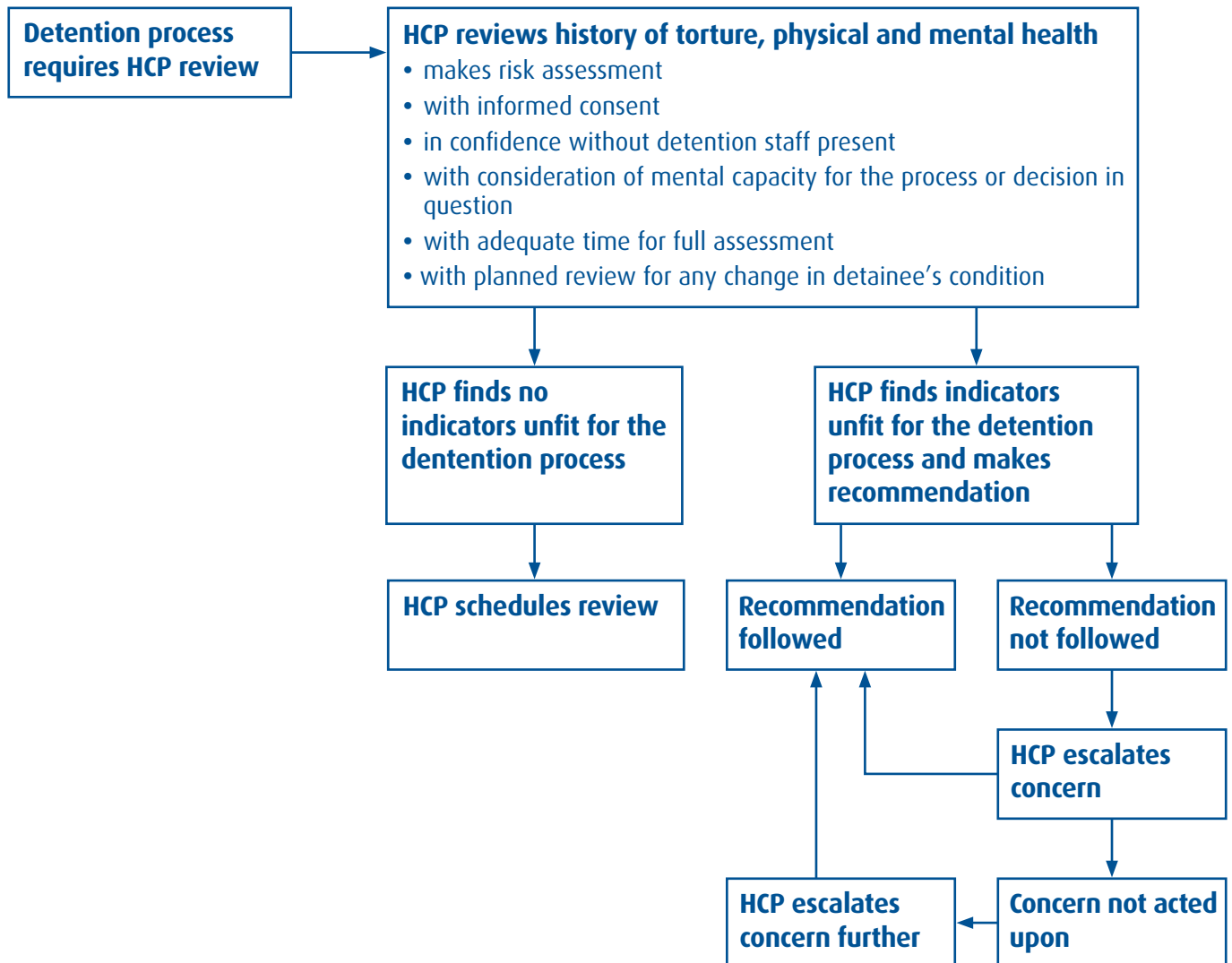
Health care professionals conform to their professional and ethical obligations, to meet the healthcare needs of their patients, raise concerns and protect them from harm.

What the quality statement means for service users:

Service users have their healthcare needs met, their autonomy maintained and are protected from harm.



ANNEX 5 Assessment required by detention processes pathway





QS10: Children

QUALITY STATEMENT

Healthcare professionals understand their responsibility to safeguard the wellbeing in detention of children and young people who are victims of torture

Rationale

All children (those individuals under 18 years⁹⁷) are vulnerable, and are entitled to the best possible health to facilitate the best possible childhood. As a consequence, the best possible care standards must be applied to all children because that is in their best interests. Ethically, there is no room for negotiation on this point unlike adults, when imperfect care can be chosen by patients, although when a capacitous child declines treatment that is in their best interest, expert multiagency and legal advice will be needed. For that reason, all the aspects of good care are laid out in this section in a manner that is not applied in other topics.

In the UK, state organisations and individuals who work with children are required to protect them from harm, making their needs their paramount concern and to cooperate with efforts to improve the welfare of all children.^{98,99} In so doing, it must be remembered that the lens of planning and action must be the 'golden thread of relationships'¹⁰⁰. If relationship considerations are not at the forefront of children's care, then the resilience of the child will not be effectively developed and harm will ensue in the form of maladaptation to adversity and an increased likelihood of mental illness and poor coping mechanisms. **It is therefore a primary responsibility of healthcare professionals to have an understanding of childhood development and how psychological symptoms may vary with each developmental stage.**

Children in settings of detention are particularly vulnerable to a host of harmful influences that need vigilance from those that are responsible for their welfare, and that will add complexity to the care of children that have been victims of torture, or have witnessed the torture or mistreatment of others. The acknowledged vulnerabilities of childhood are likely to be extended beyond the 18th birthday of those children who have been subjected to, or have witnessed, torture, unless help is offered in a timely fashion.

97. *United Nations Convention on the Rights of the Child*

(accessed 09/01/2019)

98. *Children Act 1989*

(accessed 09/01/2019)

99. *Children Act 2004*

(accessed 14/01/2019)

100. *The Care Enquiry 2013*

(accessed 09/01/2019)

This has considerable significance for healthcare professionals who work with victims of torture because they may well have to deal with

- Places of detention that deny that they hold children
- Children who are wrongly determined to be adults and who are therefore kept in adult facilities – itself a harmful practice
- Some children who have been subjected to, or who have witnessed, torture, will still be affected once they reach adulthood and are still as profoundly affected as when they were still children

Healthcare professionals need to be professionally curious enough to spot these different situations and to act upon them.

It is the first responsibility of all those working with children to be able to recognise and know how to respond to maltreatment of all forms

- physical
- sexual
- emotional
- neglect
- fabricated or induced illness

Children in detention tend to lose the following:

- the right to be heard
- respect as an individual
- respect for their views
- a normal supportive structure of family or care¹⁰¹

And when their age is incorrectly disputed and they are treated as adults when they should be treated as children, they are then not given the benefit of those services that they are entitled to as children. These include a full awareness of the rights of children to be protected from harm.

101. Green P

Children in Detention

In: Payne-James JJ, Nuno Vieira D, Beynon J. *Monitoring Detention, Custody, Torture and Ill-treatment*. CRC Press, 2018 pp204-214



Traumatic consequences of torture on children or of them witnessing torture are all the more significant because the impact will be on a developing rather than a mature adult. In any event, they are at very particular risk of:

- bullying from staff and fellow peer inmates
- abuse from adult detainees when kept in non-child detention institutes
- removal from ethnic and linguistic origins
- malnutrition
- poor gynaecological support for female adolescents
- mental health disorders including an increased risk of self-harm
- learning difficulties being unrecognised
- communication disorders

The effects of torture on children are, unless intervention is offered, bound to be long-lasting. They are compounded if they are not believed to be children when detained, when their vulnerability is not understood immediately, or worse, not recognised at all.

Unaccompanied children who may be seeking asylum are at special risk in this regard. Their experiences of positive relationships with authority figures are likely to be poorly developed, which will lead to difficulties with trusting adults in general, and consequent maladapted behaviour. The associated lack of needs being understood, and the child's voice being heard, raise further challenges for the healthcare professional. The consequences include the following:

- particular difficulties disclosing their experiences
- making coerced statements that unduly prolong their detention that will itself be damaging
- increased risk of mental illness, self-harm and suicide
- increased risk of drug and/or alcohol misuse in later years
- difficulty in forming and maintaining supportive and loving relationships in later years
- delayed development due to both psychological and nutritional factors
- physical deformity due to untreated torture injury

Exploitation

Children of all ages are at risk of systematic exploitation by peers, older children and adults when adults and children are detained together. The forms of exploitation include sexual maltreatment, coerced labour, and drug carrying. These risks are not lessened for child victims of torture, but the absence of early intervention for such victims is likely to make the road to recovery longer and more complicated as a result of the combined impact of torture and exploitation.

Quality measures

1. Communicating with children

- a. healthcare professionals must know:
 - i. about the overarching importance of positive relationships for children
 - ii. how to build and maintain trust with children who have previously been betrayed by adults, in particular those in authority
 - iii. how to seek consent in an age appropriate and supportive manner
 - iv. how to share information in an age appropriate and supportive manner
 - v. how to ensure that all handovers to colleagues and partners take all of the above into account

2. Safeguarding welfare of children

- a. healthcare professionals must know how to recognise
 - i. physical abuse
 - ii. sexual abuse
 - iii. female Genital Mutilation (FGM)
 - iv. emotional abuse
 - v. neglect
 - vi. fabricated or induced illness
- b. know how to recognise bullying
- c. know about the need to maintain family connections
- d. know how to maintain linguistic and ethnic connections
- e. know about the increased risk of mental vulnerability and associated self-harm
- f. know about the risk of drug and alcohol misuse.
- g. know about the indicators of exploitation
- h. be familiar with normal child development and behaviour
- i. be able to argue for the paramouncy of consideration of the needs of all children



3. Reporting concerns

- a. Healthcare professionals must know about mandatory reporting of FGM¹⁰²
- b. Healthcare professionals must know who to report concerns to¹⁰³
- c. Know local procedures for reporting safeguarding concerns¹⁰⁴
- d. Know how to escalate concerns that are not dealt with effectively

Quality standards

Healthcare professionals must be able to evidence:

1. With regard to safeguarding practice:
 - a. Regular child safeguarding training in line with local standards 100%
 - b. Proof of learning following training 100% for example using post training Multiple Choice Questionnaires
 - c. Reporting of safeguarding concerns to the appropriate person in the organisation 100%
 - d. Reporting of safeguarding concerns to the appropriate authorities 100%
2. With regard to healthcare consultation:
 - a. Age appropriate consent process 100%
 - b. Asking the child about
 - i. his or her wishes regarding gender of healthcare professional 100%
 - ii. cultural requirements 100%
 - c. Inclusion of adults in the medical consultation in line with child's wishes or safeguarding requirements 100%
 - d. Consideration of safeguarding risks in medical records 100%
 - e. Medical records evidence full documentation of torture when identified 100%
 - f. Evidence of effective referral to secondary and tertiary children's healthcare services when required as a result of torture or other health needs 100%

3. With regard to healthcare practice:

- a. Maintaining relationships with child patients in detention by recording of relationship maintenance meetings 100%
- b. Consistent monitoring for signs of deterioration of health or wellbeing of child patients in detention by recording of review assessments 100%

Implications

What the quality statement means for healthcare commissioners:

Assurance that the needs of children that have been tortured are being met as robustly as possible.

What the quality statement means for service providers:

Service providers ensure all healthcare professional staff are engaged in improving child welfare through their relationships with children, have required training, are aware of appropriate response to safeguarding concerns.

What the quality statement means for healthcare professionals:

Healthcare professionals provide care appropriate to the age and vulnerability of their patients and responsive to their need for safeguarding.

What the quality statement means for service users:

Their voice and wishes will be heard.

Their healthcare needs will be recognised and met.

They will be kept safe.

They will feel secure and loved.

Their needs will still be met whether they are ready to talk about their experiences or not.

102. HM Government (2018)
Multi-agency statutory guidance on female genital mutilation
(accessed 13/1/2019)

103. Department of Health
FGM Safeguarding Pathway (accessed 13/1/2019)

104. NHS England
Safeguarding Policy



QS11: Mental health

QUALITY STATEMENT

Detained victims of torture receive appropriate assessment so that their mental healthcare needs can be met

Rationale

The UN's Istanbul Protocol¹⁰⁵ reminds all healthcare professionals working with victims of torture of

'the fundamental duty always to act in the best interests of the patient, regardless of other constraints, pressures or contractual obligations'

and that in places of detention,

*'medical, including psychiatric, services must be available... without discrimination'*¹⁰⁶

The Royal College of Psychiatrists has published guidance which stipulates that

'people with a mental disorder should only be subjected to immigration detention in very exceptional circumstances',

and that detention itself is likely to precipitate a deterioration in mental health, that detention is not an alternative to in-patient care and that all care should be equivalent to NHS standards of care.¹⁰⁷

The UN standard minimum rules for the treatment of prisoners (Mandela rules) states at rule 24:

'The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.'

Rule 33 states:

'The physician shall report to the director whenever he or she considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.'

Places of detention present a series of challenges to the

105. UN Office of the High Commissioner for Human Rights (OHCHR), *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('Istanbul Protocol')*, 2004, HR/P/PT/8/Rev.1 (accessed 4 April 2018)

106. Istanbul Protocol paragraph 52 and Mandela rules 24, 25

107. Royal College of Psychiatrists *Position Statement on detention of people with mental disorders in Immigration Removal Centres* published Oct 2013, revised March 2014

assessment and management of mental health in the victims of torture, who are at higher risk of developing mental health disorders:

- the detained setting itself exacerbates psychological symptoms such that detainees are more likely than those not in detention to suffer mental ill health¹⁰⁸
- patients with pre-existing mental disorders are likely to suffer a deterioration in their mental health¹⁰⁹
- patients are likely to mistrust authorities and be less willing to disclose mental health symptoms¹¹⁰
- significant concerns have been raised regarding the process for recognising and reporting vulnerable individuals and torture victims¹¹¹
- a 'culture of disbelief' around accounts of past torture has been described as endemic in the immigration detention settings¹¹² and may also be present in other detained settings

108. Steel, Z., Silove, D., Brooks, R., Momartin, S., Alzuhairi, B. and Susljik, I.N.A., 2006 *Impact of immigration detention and temporary protection on the mental health of refugees* British journal of Psychiatry, 188(1), pp.58-64 Steel Z, Momartin S, Silove D, Coello M, Aroche J, Tay KW, 2011. Two year psychosocial and mental health outcomes for refugees subjected to restrictive or supportive immigration policies. Soc Sci Med 72:1149-1156 and Robjant, K., Hassan, R. and Katona, C., 2009. Mental health implications of detaining asylum seekers: systematic review. The British journal of psychiatry, 194(4), pp.306-312.

109. Bosworth, Mary *The Impact of Immigration Detention on Mental Health: A Literature Review* (2016)

110. Hynes, T., 2003 *New issues in refugee research. The issue of 'trust' or 'mistrust' in research with refugees: choices, caveats and considerations for researchers* Geneva: Evaluation and Policy Analysis Unit, The United Nations Refugee Agency

111. Medical Justice MJ *Adults at risk and Rule 35* Written evidence submitted by Medical Justice to the APPG on Immigration Detention

112. Shaw, S., 2016 *Review into the welfare in detention of vulnerable persons: a report to the Home Office*



- Patients may come from a culture where mental health problems lead to stigmatisation and locked wards, deterring them from seeking help for symptoms.

Despite these concerns, and reports raised to identify victims of torture and the need to release them, detention may be maintained by the authorities. Therefore a robust process is required to address the above concerns as far as possible and to ensure the best possible standard of care is delivered to victims of torture. **Essentially, while it is not appropriate to treat the mental health conditions of victims of torture in detention it is also not ethical to leave their symptoms untreated while they remain detained.** A relationship-based approach is critical to the care of torture victims, because of their difficulties with trusting others and the potentially isolating effects of mental illness.

Case study: Mental health effects of immigration detention on a victim of torture

AB, a 35-year-old man from sub-Saharan Africa was held for a week by the military after a close family member had been accused of being involved in an attempted coup. His wife and mother were also detained. During his detention he was beaten with an iron bar, raped repeatedly and witnessed the rape and abuse of his mother and his sister. He was able to escape, and had a long and difficult journey to the UK which involved being forced to do unpaid work in Libya and nearly drowning during the sea crossing from Libya to Italy. During this period, he had frequent nightmares and flashbacks in which he would hear shouting and his eldest sister screaming. AB was arrested and detained within a few days of his arrival in the UK. While he was in detention, his flashbacks increased in frequency, he had debilitating headaches and he became increasingly determined to end his life by taking an overdose. He was placed on constant observation. AB was released after a detention centre doctor submitted a report attesting to his past torture. Following his release, he became somewhat happier and calmer. AB was then re-detained and told he would be sent back to Italy. Following his re-detention, his suicidal urges returned and he became determined to jump from a landing. He was again placed on constant observation. AB was released again but, two years later, continues to have intrusive thoughts and nightmares about his experiences of detention in the UK as well as of his past torture.

Process

On arrival at a place of detention a screening process should be carried out by appropriately qualified healthcare professionals who should be working independently of detention staff. This screening would:

- look for both physical and psychological signs of torture and ill-treatment and (if such evidence is identified) (see “[QS1: Identification](#)”)
- make recommendations based on the medical grounds about continuing detention

For those held in administrative detention, this process would aim to release those individuals who are identified as victims of torture.

Within places of detention all staff ought to have training in the recognition of victims of torture as disclosure may not have been made during the health screening interview.

Monitoring patients for self-harm and suicide requires close liaison between health care and detention staff and regular multi-disciplinary review. Victims of torture can experience close observation as adding to their distress and building trusting relationships is critical.

Healthcare professionals should receive further training in:

- diagnosis and management of torture-related conditions
- the assessment of mental capacity (see “[QS5: Mental capacity](#)”)
- how to care for individuals who lack decision making capacity in relation to treatment or legal matters¹¹³

Healthcare professionals should work to ensure that appropriate multidisciplinary team treatment according to local¹¹⁴ guidance should be offered to patients found to have a mental health disorder. They should also make efforts to ensure that patients who need to leave detention temporarily for healthcare appointments are enabled to do so and do not miss appointments simply because they are in detention.

For those patients engaging in food and/or fluid refusal healthcare professionals should undertake at least daily comprehensive physical and mental health assessments.

Healthcare professionals should assess patients with a mental health disorder whose forcible removal is being considered, prior to such removal, to determine if they are unfit to fly. Healthcare professionals must advise against any such removal if their patient is found to have a condition which renders them unfit to fly¹¹⁵ (see “[QS9: Assessment required by detention processes](#)”).

113. Grant – Peterkin, H., Pickles, H. and Katona, C., 2016 *Mental capacity of those in immigration detention in the UK* Medicine, Science and the Law, 56 (4), pp.285-292

114. In the UK, National Institute for Health and Care Excellence (NICE)

115. CAA guidelines *Psychiatric-conditions* and Pickles, H. and Hartree, N., 2017 *Fitness to fly in those being forcibly removed or deported from the UK*. Journal of forensic and legal medicine, 47, pp.55-58



The main areas for concern are people whose behaviour may be unpredictable, aggressive, disorganised or disruptive or whose condition is not stable, for example patients whose psychotic symptoms are not well-controlled.

For those in need of a higher level of psychiatric treatment healthcare professionals should advise and arrange for the least restrictive option possible. In practice this means that community treatment options (such as intensive Home Treatment or Crisis Team input) should be considered before hospital admission. However, if a patient needs to be transferred to a psychiatric hospital this should be done at the earliest appropriate juncture, because places of detention should not be construed as being equivalent to in-patient psychiatric care.

When a patient is deemed fit for discharge from psychiatric hospital, return to detention after such an inpatient stay should not be construed as equivalent to community care from the Home Treatment team or similar service. Healthcare professionals working in the referring place of detention must reassess their patient to assure themselves that they are no longer unfit to be detained.

Any healthcare professional engagement with a patient where their language skills are in question should only be seen with an interpreter, with printed information sheets relating to mental health disorders to be made available (in all languages used by detained individuals).

Quality Measures

1. All individuals to be screened by appropriately trained staff for evidence of torture/ill-treatment and of mental health disorders on arrival in detention.
2. Staff should be aware that signs and symptoms can emerge during detention so any monitoring should be proactive.
3. Patients with identified mental health disorders should receive care equivalent to that available in the community.
4. All healthcare professionals should receive regular training on the recognition of both signs of torture and signs of mental disorder. This training should be by an appropriately qualified provider who works regularly with in a clinical setting, not staff employed by the detention authority.
5. Appropriately detailed risk assessments should be made as part of routine care, and regularly reviewed, with multidisciplinary meetings including all those involved in the process of monitoring for self-harm.
6. Appropriately detailed assessments of an individual's mental capacity should be made alongside the assessment process as well as any decisions regarding care, these should be regularly reviewed.
7. Whenever an individual leaves detention consideration should be made as to need for any onward care and they should be referred to appropriate local service.

8. Immigration detainees who are identified as being victims of torture should be brought to attention of the detention authorities with a view to them being released. The Committee for the Prevention of Torture (CPT) considers that 'there should be meaningful alternatives to immigration detention' for victims of torture.¹¹⁶

Quality Standards

1. Medical records demonstrate that the proportion of individuals screened for mental health disorders within the first 24 hours of detention by an appropriately skilled healthcare professional should be 100%
2. Medical records demonstrate that those not in crisis but requiring specialist mental health assessment were seen within one week of arrival 100%
3. Healthcare professionals who have received training in mental health assessment and care 100%
4. Medical records demonstrate that mental health care shows
 - a. clear evidence of multidisciplinary team approach
 - b. documented care plans
 - c. specific reference to individualised treatments to address
 - i. biological
 - ii. psychological and
 - iii. social aspects of treatment
 - d. review to assess if mental health is deteriorating in detention and therefore if the patient is unfit for continued detention
 - e. escalation of concern if recommendations about mental healthcare and unfitness for detention are not followed
5. Medical records demonstrate accurate records of indications for the use of all psychotropic medication
6. Medical records demonstrate accurate records of all psychotropic medication prescriptions
7. Medical records demonstrate detailed recording of all incidents of self-harm
8. Medical records demonstrate record of action taken in all incidents of self-harm i.e. appropriate referral to mental health professional and review of unfitness for continued detention
9. Healthcare professionals to demonstrate regular and frequent reviews of self-harm monitoring mechanisms, including those carried out by non-clinical staff
10. Medical records demonstrate proactive follow up of patients not attending appointments or refusing medication, to assess for deterioration of their condition

116. European Committee for the Prevention of Torture and Inhuman or Degrading Punishment
Factsheet on immigration detention March 2017



Implications

What the quality statement means for healthcare commissioners:

Assurance that all victims of torture whilst in places of detention receive appropriate assessment and treatment for mental health conditions equivalent to those in the community.

Assurance that mental health of victims of torture is monitored effectively whilst in places of detention.

What the quality statement means for service-providers:

Service providers ensure all healthcare professionals have training in assessment and management of mental health conditions and utilise referral pathways.

What the quality statement means for healthcare professionals:

Healthcare professionals are appropriately trained for the healthcare needs of victims of torture, the common mental health conditions they suffer, assessment of mental capacity and risk factors for self-harm and suicide (see *"QS8: Training"*).

Healthcare professionals work as part of a multidisciplinary team communicating with non-clinical detention staff and agencies outside detention.

Healthcare professionals train and support non-clinical staff in risk assessment and monitoring for self-harm and suicide.

What the quality statement means for service-users:

An environment that empowers individuals to make choices about care but can also recognise and support those individuals who lack mental capacity to make decisions.

Integrated connection with healthcare providers outside detention setting.

Information regarding mental health conditions is available, enabling their input into the healthcare they receive.



QS12: Sexual violence

QUALITY STATEMENT

Detained victims of torture who have past experiences of sexual violence receive appropriate assessment so that their healthcare needs can be met

Rationale

Experiences of sexual violence are not limited by gender.^{117,118} It is a common method of torture although victims do not always disclose it.¹¹⁹ The Istanbul Protocol notes at paragraph 215

'Sexual torture begins with forced nudity, which in many countries is a constant factor in torture situations. One is never as vulnerable as when naked and helpless. Nudity enhances the psychological terror of every aspect of torture, as there is always the background of potential abuse and rape. Furthermore, verbal sexual threats, abuse and mocking are also part of sexual torture, as they enhance the humiliation and its degrading aspects, all part and parcel of the procedure.'

The wider definition of torture as described in the overview of this document brings into consideration not only victims of torture but victims of sex trafficking and other experiences of sexual violence.

Difficulties in disclosure (see "[QS1: Identification](#)") of such experiences may result in a person not seeking help.^{120,121} They may then go without the medical attention for their injuries and psychological support they need.

In particular, in relation to sexual violence this may be due to:

- fear of not being believed
- fear of being blamed

117. WHO 2002

World Report on Violence and Health Chapter 6
(accessed 10/01/2019)

118. *Istanbul Protocol, the UN Manual on the Effective Investigation and Documentation of Torture and other cruel inhuman or degrading treatment or punishment* paragraph 216
UN OHCHR 2004 (accessed 09/01/2019)

119. *Istanbul Protocol* paragraph 217
UN OHCHR 2004 (accessed 09/01/2019)

120. Patterson D, Greeson M, Campbell R
Understanding rape survivors' decisions not to seek help from formal social systems
Health and Social Work 34;May 2009:127-136

121. Chesler P
Worldwide trends in honour killings
Middle East Quarterly 2010 pp3-11

- shame
 - difficulty in trusting authorities
 - anxiety about confidentiality
 - community stigma
 - fear of 'honour-based violence' from family or community members
- and lack of knowledge of:
- availability of testing and treatment facilities
 - access to interpreters
 - right to choose gender of healthcare professional

Therefore, it should not be assumed simply because the sexual violence is historic and not recent, that healthcare issues no longer need to be identified and addressed.

Process

The issues of concern relate to physical health, psychological health, sexual health and reporting of the crime, and in relation to each of these the possible courses of action should be discussed with the patient.

The patient should be asked if they have a preference for the gender of healthcare professional and interpreter and if they would like a chaperone to be present.

Physical health assessment needs to include review of symptoms of possible:

- sexually transmitted infection
- past or current pregnancy
- FGM
- lower abdominal pain
- damage to the ano-genital tract such as tears
- fistulae
- bladder dysfunction
- incontinence of urine, faeces or flatus

and review of injuries to other parts of the body that may have been sustained during the assault. (see also "[Annex 1 Indicators of past experience of torture](#)").



Referral to a specialist unit for examination of victims of sexual assault and referral to the police should be discussed with the patient.

The quality standards of the British Association for Sexual Health and HIV (BASHH) for outreach care and management of sexually transmitted infections should be implemented.¹²²

Assessment of the psychological impact of experiences of sexual violence and consequent treatment needs is also important, particularly due to the stigma attached to both disclosing sexual violence and seeking treatment for mental health problems in many cultures, and the high rates of mental health problems in complainants of sexual violence.¹²³ Suicide risk and safeguarding concerns for any children or vulnerable adults involved should be assessed (see “[QS10: Children](#)” and “[QS11: Mental health](#)”).

Difficulty in retaining the information given, if it is only in verbal form, can occur in other areas of health care, but victims of torture and sexual violence in particular can have difficulty in taking in this information and retaining it. The psychological phenomenon of avoidance, as well as other mental health issues, and the fact that due to being in detention they may be moved around and miss follow up appointments can exacerbate the problem. It is important that people are fully informed of what tests have been done and of what the results obtained mean.

Quality measures

1. Persons disclosing any past history of sexual violence should have their physical and psychological health needs assessed
2. Patients should be offered choice regarding gender of healthcare professional and interpreter
3. Patient should be offered a chaperone
4. In-house testing or referral for screening for sexually transmitted infections should be made, subject to the patient’s informed consent
5. Patients undergoing screening tests should receive verbal and written information about the tests done and their results in a format that they can understand
6. Patients should be offered appropriate medication or psychological therapy based on the assessment of their psychological state, and this may entail recommending their release (see “[QS11: Mental health](#)”)
7. Patients should be screened for risk of suicide, self-harm, domestic violence and honour-based violence

122. British Association for Sexual Health & HIV
[STI Outreach Standards](#) (accessed 09/01/2019)

123. Brooker C, Tocque K
Mental health risk factors in sexual assault: what should sexual assault referral centre staff be aware of?
J Forensic Legal Medicine 40; May 2016: 28-33

Quality standards

For all those disclosing past history of sexual violence including sex trafficking, records demonstrate:

1. A full assessment offered 100%
2. Record of reason for declining such assessment 100%
3. Chosen gender of healthcare professional and interpreter is provided 90%
4. Records demonstrate chaperone is offered
5. Physical assessment made 100%, including
 - a. appropriate screening tests for infections, 100%
 - b. informed consent documented 100%
6. Psychological assessment made 100%
7. Care follow up plan for review of results, physical and mental health treatment and onward referrals as needed 100%
8. Verbal and written information given to the patient in the care plan in a form they can understand 100%
9. Assessment for harm to self, or from others, with any necessary actions 100%

Implications

What the quality statement means for commissioners:

Health care commissioners commission services that provide a good standard of care for victims of sexual violence.

What the quality statement means for service providers:

All service providers employ staff trained in screening for sexually transmitted infections and have referral pathways in place for GUM investigation of sexually transmitted infections/FGM including for referral to sexual assault referral centre (SARC).

What the quality statement means for health care professionals:

All health care professionals have competence in screening for sexually transmitted infections and assessment of the health care needs of victims of past sexual violence.

What the quality statement means for service users:

Service users are:

- enabled to disclose their health needs and concerns about experiences of sexual violence in a safe, caring environment
- enabled to access appropriate investigation and treatment
- given verbal and written information regarding tests and their results or other outcomes



Glossary

Anonymised aggregated form – data without any identifying details and with totals rather than individual values

BASSH – British Association for Sexual Health and HIV

Bio-psycho-social model – systematically considers biological, psychological, and social factors and their complex interactions in understanding health, illness, and health care delivery

BMA – British Medical Association

CAA – Civil Aviation Authority

Capacitous – being able to understand information to make your own decisions

Dissociation – disconnection from surroundings with disruption of aspects of consciousness

Emotional lability – rapid changes of heightened emotions

FFLM – Faculty of Forensic and Legal Medicine

FGM – Female genital mutilation

Fistula – an abnormal passage between two organs in the body

Flatus – gas expelled from the gut

Gastritis – inflammation of the stomach

Gastrointestinal – relating to the stomach and gut

GDPR – General Data Protection Regulation

Grounding techniques – techniques used to connect and re-orient a person with the present time and place, useful in managing anxiety and flashbacks

HCP – Healthcare Professional

HIV – Human Immunodeficiency Virus

Honour-based violence – a **violent** crime or incident which may have been committed to protect or defend the **honour** of the family or community

Hyper-vigilance – the state of being highly or abnormally alert to potential danger or threat

IRC – Immigration Removal Centre

ISTANBUL PROTOCOL – United Nations Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment

Mental capacity – a person with this is able understand information to make their own decisions

Meta-analysis – examination of data from a number of independent studies of the same subject, in order to determine overall trends

Named capacity lead – the person responsible for leading practice on assessment of mental capacity in an institution

Nelson Mandela Rules – United Nations Minimum Standards for the Treatment of Prisoners

NICE – National institute for Health and Care Excellence

Psychological sequelae – consequences to health affecting the mind and emotions

PTSD – Post traumatic stress disorder

Rehabilitation – the action of restoring someone to health or normal life through therapy

Safeguarding – protecting children and promoting their welfare, and protecting vulnerable adults from abuse or neglect

SARC – Sexual Assault Referral Centre

Sensory deprivation – someone is deprived of normal external stimuli such as sight and sound for an extended period of time

Stigma – mark of perceived disgrace associated with a particular circumstance, quality, or person

Trauma informed care – practices that promote a culture of safety, empowerment, and healing

UK – United Kingdom

UNCAT – United Nations Convention Against Torture

UNHCR – United Nations High Commissioner for Refugees

Vicarious traumatisation – effects on a trauma worker from empathic engagement with traumatized clients

Vulvovaginitis – inflammation of the external female genitals and vagina

WMA – World Medical Association



These quality standards are endorsed by:



Freedom from Torture

Helen Bamber 
Foundation

working with survivors of human cruelty

Helen Bamber Foundation



The United Kingdom
Association of Forensic Nurses

Produced by the FFLM HWVT Working Group, co chaired by Dr Juliet Cohen and Dr Peter Green
on behalf of the Faculty of Forensic & Legal Medicine

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