

'IF SOMEONE IS SUFFERING, DOES HE HAVE TO BE KEPT IN AN ISOLATION CELL?'



Introduction

Immigrants without a right of residence can be placed in detention in the Netherlands. Thousands of immigrants are detained each year in the Netherlands because they are not permitted to enter the country and are detained at the border for that reason, or because they have to leave the Netherlands and may be expelled. In these cases, immigrants lose not only their liberty, but may also be subjected to other drastic measures. One of those is the use of isolation.¹

Isolation is problematic both from a human rights and a medical perspective – especially in immigration detention. Human rights standards impose strict requirements on the use of isolation. It may only be applied in exceptional circumstances, if it is absolutely necessary, proportionate and non-discriminatory. Moreover, such cases require consistently good accountability. Medical research shows that isolation – even if short-term – can be detrimental to mental health. For this reason the mental health sector aims to reduce and eventually eliminate the use of isolation.

The Dutch government, too, has expressed its wish to curb the use of isolation in immigration detention. Nevertheless, a joint study by Médecins du Monde the Netherlands, Amnesty International the Netherlands and the LOS Foundation has found that the use of isolation has not diminished in recent years. Between January and October 2014, 379 immigrants in administrative detention were placed in isolation. The percentage has been stable for years: an average of 1.2 or 1.3 percent of detained immigrants are held in isolation each day. This may seem a negligible percentage, but it means that hundreds of immigrants are held in isolation each year, with potentially detrimental health effects.

This research shows that despite the intention to prevent the use of isolation, legislation, policy and practice have hardly changed in recent years in order to really do so. Urgent changes are needed.

This spring the Dutch government is considering a bill which would change a number of issues related to immigration detention. This is the perfect opportunity to finally make a serious effort to reduce of the use of isolation. This document is the contribution by Médecins du Monde the Netherlands, Amnesty International the Netherlands and the LOS Foundation to this discussion.

RESEARCH

In order to prepare this report, the National Agency of Correctional Institutions (NACI, Dienst Justitiële Inrichtingen) was asked to provide information about isolation, concerning frequency, duration and policy. Visits were made to the Rotterdam, Zeist and Schiphol detention centres in August and September 2014. The three above-mentioned organisations organised the expert meeting ‘isolation in immigration detention’ on 19 September 2014, in which academics, lawyers, doctors, representatives of regulatory bodies and NGOs exchanged views. In addition, the organisations used mental healthcare studies available in the public domain and information from an earlier visit by Amnesty International to immigration detention centres in Sweden, supplemented by further, more recent data obtained from the director of a Swedish detention centre.

This document presents the main findings and conclusions of the study, and recommendations for changes in legislation, policy and practice. The complete research report *Isolatie in vreemdelingendetentie (Isolation in immigration detention)* is available in Dutch at www.doktersvandewereld.org/notitie-isolatie-vreemdelingendetentie

¹ There is no single definition of isolation. Many terms and definitions refer to (various forms of) isolation in the literature, policy documents and in daily practice. For this reason, this report bases its use of the term on law and policy on isolation in detention and its practical implementation. In detention centres, the terms seclusion, isolation and observation are often employed. In mental health care the word ‘separation’ is often used. In this report, we use the terms ‘isolation’ and ‘isolation cell’. We restrict the term ‘solitary confinement’, as used in the international literature, to direct quotes or references.

1 - Isolation in Dutch law and policy

For immigrants in detention awaiting expulsion² – which is the majority of detained immigrants – conditions in detention sites are governed by the Penitentiary Principles Act (PPA)³.

This means that these immigrants, who are in administrative detention, are subject to the same conditions for the use of isolation as people who are imprisoned because they have committed a criminal offence.

The PPA states that isolation can be used as a disciplinary measure or as a measure to maintain order (an order measure). A disciplinary measure may be imposed if an immigrant does not adhere to the detention centre rules. For example, if he refuses to be put in a cell with other people, or threatens other immigrants or detention staff. The purpose of the sanction is explicitly to punish the immigrant for this behaviour. An order measure may be applied to maintain or restore either order in the detention centre or safety of the immigrant, other detainees or staff.

The PPA⁴ does not apply to border detention, which has a slightly milder regime based on the Regulation on Border Accommodation (RBA)⁵. The RBA does not permit disciplinary measures, but allows the use of isolation as an order measure. Isolation can be imposed when it is absolutely necessary for safety and order in the facility, or to prevent escape from detention. An immigrant can also be placed in isolation at his own request.

Despite broad powers to use isolation in immigration detention, the Ministry of Security and Justice's official policy is that isolation, also in immigration detention, should be avoided as much as possible. *The Guidelines for disciplinary punishments and order measures*⁶, formulated by the 'Special Facilities Directorate' in 2010, identifies the use of alternative means as the desirable starting point, before resorting to isolation if necessary.

Monitoring isolation in immigration detention in the Netherlands is the responsibility of the Inspectorate of Security and Justice (IV&J) and the Netherlands Health Care Inspectorate (IGZ).

2 This is based on Article 59 of the Aliens Act 2000. This is also sometimes called 'Article 59 detention'.

3 Penitentiare Beginselenwet in Dutch.

4 Border detention takes place when entry to the Netherlands is refused at the border. This includes, amongst others, people who claim asylum at Schiphol Airport. Detention is based on Article 6 of the Aliens Act 2000. Border detention is therefore also called 'Article 6 detention'

5 Reglement Grenslogies in Dutch

6 Leidraad disciplinaire straffen en ordemaatregelen in Dutch.

2 – Isolation and human rights standards

Isolation is related to various human rights. Of special importance is the risk of violating the prohibition of torture and inhuman or degrading treatment or punishment. This ban is enshrined inter alia in the European Convention on Human Rights (ECHR), the EU Charter of Fundamental Rights, the International Covenant on Civil and Political Rights and the UN Convention Against Torture. The use of isolation is not necessarily in conflict with the ban.

Several institutions have formulated conditions for the use of isolation. One of them is the European Committee for the Prevention of Torture (CPT). The CPT states that the grounds for isolation and the power to impose it must be clearly established in law. In addition, isolation may only be used when strictly necessary. That is, if no less intrusive means are available to – in this case – ensure safety or order in the detention centre. Moreover, the use of isolation must be proportional, considering the potentially harmful effects of isolation in relation to the objective. Isolation may also not be used in a discriminatory fashion and its use must be accounted for, which includes recording decisions to put people in isolation. Immigration detention may, according to the CPT, never have a punitive character.

It may also conflict with other human rights, such as the right to respect for a person's private and family life which is protected inter alia by Article 8 of the ECHR. This right includes the right to physical and mental integrity. An infringement of this right through isolation may be legitimate if certain conditions are met. Again, the measure must always be necessary and proportionate.

The UN Standard Minimum Rules for the Treatment of Prisoners and the European Prison Rules also prescribe restraint when using isolation. These rules are mainly focused on the rights of criminal prisoners. For administrative detainees one should expect even more restraint.

3 - What is isolation and what does it mean for someone in immigration detention?

THE ISOLATION CELL⁷

When isolation is imposed as a disciplinary measure, the detainee usually ends up in a 'bare cell', or 'punitive isolation cell', which only contains a toilet, a 'seating element' during the daytime and a mattress, a pillow and a blanket at night. A seclusion cell is used for order measures. This is the same as a punitive isolation cell, but often has both a seating element and a mattress with a blanket during the daytime, and furnishing may vary a little depending on the detention centre and the reason for placement. The cell has a window measuring at least 0.7 square meters and ventilation. The corners of the cell are chamfered, so that the guard can always see the prisoner from the corridor. The detainee in the isolation cell can communicate with the guards, but when this is done repeatedly without necessity, the director may decide to disable the communication device. The isolation cell door may only be opened with at least two members of staff present. There may be a camera in the cell which monitors the entire cell. The heating and light are operated from outside the cell. The director may decide to keep the lights on at night. Detainees may also be placed in a 'strip cell', for instance if there is a risk of suicide. This is more like a normal cell, but the furnishings have been adapted to reduce the risk of suicide.

WHAT HAPPENS TO SOMEONE IN ISOLATION?

Before an immigrant is placed in isolation, he has to hand in his clothes and other belongings. He is then subjected to a full body search, which entails fully undressing and having one's body examined. Immigrant accounts reveal that they often find this extremely humiliating, and occasionally traumatising. After criticism from the Dutch parliament, body scanners were installed in the Rotterdam Detention Centre to replace full body searches. Nevertheless according to the testimony of several detainees, full body searches are still conducted there prior to placement in an isolation cell. If a detainee refuses to cooperate with the full body search, he can be sent to a punitive isolation cell for between one and three days. The immigrant is still subjected to a full body search, by force if necessary. The detainee is only allowed to wear clothing provided by the detention centre in the isolation cell. That may be a safety (or 'anti-suicide') smock, a safety suit or pyjamas. The detainee is not given underwear. Safety clothing is made of thick fabric that cannot be torn. A safety smock is often about 1.3 meters long, wide and rectangular, with holes for the arms and head. A safety suit consists of trousers and a smock.

The regime in an isolation unit varies from detention centre to detention centre. In the case of a disciplinary measure, all of the centres lock the isolation cell doors. Depending on the detention centre, every sixty or ninety minutes there is contact with detention staff, who look through the hatch or open the door. The detainee is allowed to smoke several times a day.

In the case of an order measure, freedom of movement differs from centre to centre and depends on a detainee's situation and condition. This varies from conditions comparable to a disciplinary measure – the door always being locked except when the detainee is allowed outdoors, to the door being open as often as in the regular unit, to only being kept in isolation at night.

7 Regulation of penal and isolation cell correctional facilities, PPA and 'Guidelines for disciplinary punishments and order measures', Special Facilities Directorate, 2011.

A person in isolation is legally entitled to at least one hour of fresh air each day. In practice, they are allowed fresh air twice a day for an hour. The place they are allowed fresh air (often called an 'air cage') is indoors. It has concrete walls and the sky is visible through a grid which forms the ceiling.



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HEALTH PROBLEMS CAUSED BY ISOLATION

Research into the health effects of isolation has repeatedly demonstrated its negative consequences.

Common adverse effects include suicidal thoughts and behaviour, emotional breakdown, chronic depression, uncontrollable anger, hallucinations and high blood pressure.

In 2008 the IGZ characterised immigrants in detention as 'extremely vulnerable, lonely and socially dislocated people who are sometimes in a desperate situation.' Many immigrants have pre-existing health problems, which are often exasperated in detention. What is more, those who already suffer from psychiatric disorders are at greater risk of ending up in isolation, because isolation is used as a management tool with which to maintain order in detention. This can result in further deterioration of their mental health.



DETAINEES' EXPERIENCES

'When I had been in detention for a week I received very bad news about my son, whose life was in danger. I was very upset. I cried and hit myself. One of the members of staff, who spoke my language, heard me say I would take my own life. After a while four people came and said, 'We've heard you want to commit suicide. We're going to take you to another cell.'

But they didn't tell me I was going to an isolation cell. There was a toilet in the cell, a bare mattress and only one blanket. It was very hard for me.

I spent one night in an isolation cell. They take your clothes from you, you sleep on a mattress, and you're watched by a camera. They said it was for my safety. I replied: 'I'm so cold, is that is for my safety? I'm just getting sicker here.' I cried that whole night, and they were watching me.

Was this my punishment? If someone is suffering, does he have to be kept in isolation?'

Many immigrants have indicated that they feel powerless about being placed in isolation. They can file a complaint if they are placed in isolation, but they often do not know how. The determination in which the punishment is explained is often in Dutch, which is not sufficiently understood by all immigrants. Their lawyer is not automatically notified and they do not always get the opportunity to call their lawyer. The complaint has to be submitted within seven days, and the verdict can take four weeks to be delivered, while the imposition of the punishment is not suspended during that time. For this reason, many immigrants consider the complaints procedure not very worthwhile. If the complaint is upheld, the person who was held in isolation receives compensation amounting to ten euros a day, which makes them feel they are not taken seriously.

The Immigration Detention Hotline received 34 complaints about isolation in 2014. The most common complaints were: having to wear safety clothing, the use of force while being placed in isolation, being threatened with isolation by detention staff, and poor access to books and magazines. Almost all immigrants complained about the isolation cells being cold. The person in isolation gets one blanket and often no sheets. He can ask for more blankets, but in practice they are not always provided.

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B., a 30-year-old man with no history of mental illness, finds his cellmate shortly after he has attempted to commit suicide. He immediately raises the alarm. B. is very upset afterwards. When he sees the emergency physician⁸, he tells him he wants to commit suicide, like his cellmate. The physician decides to put B. in an isolation cell with camera surveillance for his own safety. He agrees with the GP and the behavioural expert to re-evaluate B. the next day.

The next day the GP finds a frightened man in the isolation cell, with whom it is not possible to make contact. He stares blankly and regularly hides under his pillow. The doctor suspects he is in a state of psychotic decomposition. B. is sent back to the regular ward, where his behaviour is observed.

Two days after the incident, prison officers notice that B. is behaving in an increasingly odd manner. An emergency physician is called once more, who sees no evidence of suicidal tendencies. He decides that B. requires extra care and attention (if needs be in the presence of an interpreter) and that he cannot be placed in an isolation cell again. His file makes no mention of any evaluation of his placement in isolation.

More than a week after the incident the psychiatrist prescribes an antipsychotic medicine. After six months B. is released from detention, as there is no prospect of him being expelled. Six months later he is on antidepressants and is still being treated by a psychologist.

8 Emergency physicians are referred to as 'he' in this account. However, it is not known whether they were male or female doctors.

4 – Situation on the ground

NUMBERS

In the period from January to October 2014 there were 379 isolation placements in immigration detention in the Netherlands. In absolute terms, this is a significant decrease compared to previous years. But the total number of immigrants in detention decreased proportionately in the same period; the percentage of isolation placements has been stable for years. The proposed reduction in isolation placements is not reflected in the figures.

Number of isolation placements	2011	2012	2013	2014 (Jan – Oct)
Inflow immigration detention	6104	5420	3670	2304
Isolation placements (total)	1100	741	662	379
Average number of people in an isolation cell per day	18	12	8	Unknown
Percentage of population in isolation cells	1.3%	1.2%	1.3%	Unknown

An isolation measure is always imposed for a predetermined period. For example, 14 days in a punitive isolation cell for attempting to escape, 14 days in a punitive isolation cell for refusing to be kept in cell with other people and an order measure of 1 to 14 days isolation for attempted suicide. The director of the detention centre can rescind isolation placements – which rarely happens in the case of disciplinary measures; and is a regular occurrence in the case of order measures.

Average duration isolation placements in days	2012	2013	2014 (Jan – April)
Average duration disciplinary sanction	5.4	4.8	7.1
Average length order measure	5.2	4.5	5.4

An isolation measure may also be extended. This happened thirteen times between January and April 2014 at the Rotterdam Detention Centre. The figures show that there was one case of repeated extension, leading to a total isolation period (as an order measure) of 29 consecutive days. There were significantly less extensions in other detention centres.

REASONS FOR THE USE OF ISOLATION

Disciplinary sanctions

A third of isolation placements in the first half of 2014 were the result of a disciplinary sanction. The reason for this was usually unacceptable behaviour by the immigrant towards staff (30.8 percent) or towards other detainees (21.0 percent). But refusing to stay in a cell with other people was often the reason for isolation (13.2 percent). Other reasons that were registered included the possession of contraband (11.9 percent) and disrupting peace and order or endangering safety (9.1 percent).

ORDER MEASURES

By far the most cases of isolation due to order in the first half of 2014 occurred on medical grounds (66.9 percent). Around 20 percent of the cases were related to disturbance of the peace or order, or for endangering safety. To a lesser extent, isolation due to an order measure was on a detainee's own request (8.9 percent), or because of unacceptable behaviour towards other immigrants (2.8 percent). Because medical reasons play such a prominent role in isolation placements, closer examination is useful.

Order measures due to medical reasons specified in 2014(January - June)	Number	Percentage
Threatening suicide	68	57.1%
Confusion	20	16.8%
Hunger strike and/or refusing fluids	7	5.9%
Attempted suicide	7	5.9%
Medical advice (not specified)	6	5.0%
Self-harm	3	2.5%
(Suspicion of having an) infectious disease	3	2.5%
Refusal of medication	2	1.7%
Refusal of medical check-ups	2	1.7%
Hoarding medication	1	0.9%
Total	119	100%

SUICIDE

Isolation placement on medical grounds is often related to threatening suicide (57.1 percent) or, less frequently, attempted suicide (5.9 percent). Various supervisory authorities have been dealing with the prevention of suicide in immigration detention. In 2014, the Netherlands Health Care Inspectorate (IGZ) found that the assessment of the psychological condition of detainees was insufficiently systematic and that existing protocols were still too focused on management, and therefore possibly not on protecting detainees.⁹

After the death of Alexander Dolmatov, a Russian asylum seeker who committed suicide in a Dutch detention centre in January 2013, suicide in detention has received more attention. According to the Inspectorate of Security and Justice (IVenJ), protocols and work instructions addressing the issue of psychological vulnerability and how to act when that vulnerability arises have now been revised.¹⁰

That is positive, but the downside of this desire to avoid a new 'Dolmatov' is that when there is a suicide threat, staff swiftly resort to isolation. Healthcare professionals are confronted by a dilemma: isolation means risk prevention, but it also means imposing a heavy and potentially harmful measure.

'It was in Rotterdam Detention Centre that a discussion about isolation started. The approach was:

⁹ IGZ 2014, p. 7.

¹⁰ IS&J *monitor Vreemdelingenketen* p. 22 and 96.



‘You can’t really place people in isolation as it has such a huge impact on them.’ But you have to imagine that dealing with suicidal tendencies on a daily basis is like for healthcare professionals. When the umpteenth refugee says “I’ve given up, I’m going to end it all...”. Yes, it affects you. But at the same time you sort of get used to it.

After Dolmatov’s death you see that staff are very strict once more and everybody is placed in isolation. You can ask yourself: is that okay or not?

A participant at the expert meeting ‘Isolation in detention’, 19 September 2014.

HUNGER STRIKES AND REFUSING FLUIDS

In the first half of 2014, hunger strikes and refusing fluids was the cause of 5.9 percent of isolation placements as an order measure.

The Forensic Medical Society Utrecht (FMMU), the healthcare provider in detention centres, advises against the isolation of hunger strikers and those refusing fluids. It wrote in a guideline that ‘it is absolutely contraindicated on medical grounds’.¹¹ A spokesman for the Johannes Wier Foundation, a resource centre for human rights and health, is of the opinion that: ‘There is no medical reason to argue for seclusion or camera surveillance of hunger strikers and those refusing fluids. However, it is important to do medical checks.’¹²

According to the Minister of Security and Justice, the Rotterdam Detention Centre is supposed to have added to a work instruction that placement in an isolation cell is contraindicated, as long as there are other means available to influence behaviour or to monitor the detainee’s physical condition.¹³ It is noteworthy that this explicit instruction is necessary, as isolation may only ever be used if all other measures have been exhausted. The decisions that were issued to hunger strikers in Zeist in early 2013 show that by default they were placed in an isolation cell with camera surveillance 24 hours after the start of their hunger strike.¹⁴ Isolation of hunger strikers has also occurred at Schiphol Detention Centre. When dealing with a hunger striker’s complaint about being placed in isolation, the Supervisory Committee ruled that this is impermissible in any case: if hunger strikers are segregated, it must be in a cell that is furnished like a standard cell. Neither may hunger strikers be required to wear ‘protective clothing’.¹⁵

During a joint visit by Amnesty International, Médecins du Monde and the LOS foundation, one detention centre director stressed explicitly that placement in isolation was not intended as a coercive measure to force hunger strikers to resume eating; it was supposed to be a means to give them more personal attention.

11 FMMU 2013 (Forensic Medical Society Utrecht), Guideline medical supervision of hunger striking detainees/detainees refusing fluids.

12 Dr. L. van Willigen (Chairman of the Johannes Wier Foundation), expert meeting ‘isolation in immigration detention’, 19 September 2014

13 Letter from the Minister of Security and Justice. House of Representatives of the Netherlands, 2012-2013, 24 587, no. 536, p. 2.

14 Freedom of Information Act decision, 2013 (incidents Zeist Immigration Detention Centre, March-April-May 2013) (in Dutch), <http://openbaarheid.nl/wob-resultaten/incidenten-vreemdelingendetentie-2013> (accessed 26 January 2015).

15 Supervisory Committee ruling 08/08/2013 Case number: KC 2013/032.

MENTAL HEALTH PROBLEMS

'Confusion' was the cause of 16.8 percent of the isolation placements on medical grounds in the first half of 2014. During the expert meeting 'isolation in detention', which was held in September 2014, detention staff said that they are regularly confronted with psychiatric patients who react oddly or aggressively.¹⁶ So a situation can easily get out of hand. Incidents regularly take place in which punitive isolation placement is the result of dealing inadequately with a person with a mental condition. Participants at the expert meeting stressed the importance of sufficient expertise and good training of (healthcare) staff dealing with psychiatric patients. According to current mental health and forensic psychiatry standards (see chapter 7), making contact – and not severing it due to isolation – is a critical part of care provision.



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'Order measure: due to severe confusion, you have been placed in an isolation cell with camera surveillance.'

¹⁶ Expert meeting 'isolation in detention, 19 September 2014, Working Group on Health and Care Provision in Immigration Detention.

5 – What is going wrong?

Despite the intention to reduce isolation in immigration detention, the figures show that this has failed. The total population in immigration detention has been falling for several years – and with it, the number of isolation placements – but the percentage of people placed in isolation has remained the same. Isolation has therefore remained a reality for hundreds of immigrants each year.

The use of isolation as a disciplinary measure is a cause of great concern for Médecins du Monde, Amnesty International and the LOS foundation. International rules require considerable restraint in the isolation of prisoners who have committed a criminal offence. Even more restraint is appropriate in the case of immigrants, a vulnerable group of detainees who have been detained on administrative grounds. Several organisations have criticised the fact that conditions in Dutch immigration detention centres are often the same as in prisons, and in some aspects even stricter. The European Committee for the Prevention of Torture specifically states that immigration detention must ‘avoid as far as possible any impression’ of a prison environment, and that detention may not have a ‘punitive character’. The imposition of disciplinary measures, particularly of drastic and risky measures like isolation, conflicts with these principles. Isolation as a disciplinary measure is therefore incompatible with immigration detention. The power to impose isolation on immigrants for their behaviour should be revoked without delay.

According to international standards, isolation for order and safety reasons is permissible in exceptional situations, but only when there is really no milder means available. However, this study demonstrates that there is no clear vision for preventing the use of isolation as an order measure in Dutch detention centres. As such, the Ministry of Security and Justice gives its staff too few means to handle the challenges of immigration detention, other than to resort to a radical measure like isolation. That can result in an unsafe situation – for both detainees and staff.

Immigrants in turn have little ability to respond appropriately to being placed in isolation or to the conditions during their isolation. Complaint procedures are flawed and comply with Dutch legislation – which provides ample opportunities for isolation placement – and not with international human rights standards. Knowledge about the effects of isolation is not factored into decisions. Even when the complaints commission rules in an immigrant’s favour, the compensation is woefully meagre, while this kind of improper placement can cause great emotional harm and damage to health.

It is also noteworthy that the inspectorates monitoring (isolation in) immigration detention, the IV&J and the IGZ, are not fully committed to eventually eliminating isolation in immigration detention. At the same time the IGZ is pursuing the IGZ guidelines for elimination in other contexts (see chapter 7). Both inspectorates have been designated as National Prevention Mechanisms (NPMs) in accordance with the Optional Protocol to the UN Convention against Torture. As such they have a special responsibility to monitor situations in which there is a risk of torture or inhuman treatment, and encourage preventive action. This is an important shortcoming on the part of the inspectorates.

6 - The Repatriation and Immigration Detention Bill

The political debate about immigration detention and the conditions in detention centres has had added impetus since the death of Dolmatov. The former Minister of Security and Justice, Frederik Teeven, promised a number of improvements, particularly in a new Repatriation and Immigration Detention Law. This bill is a unique opportunity to properly address some of the issues related to the use of immigration detention, including isolation, and consign them to the past.

A draft bill was published in December 2013 for public consultation. At the time of writing the bill had been sent to the Council of State for consultation. It is expected to be put before parliament in the spring of 2015.

Yet the bill is likely to be a missed opportunity. In many points, the old (criminal) legislation has been adopted, with a small shift here and there. There certainly does not seem to be any real improvement when it comes to isolation. Although the intention of the bill was to give immigration detention an administrative legal character, there already seems to be little more hope of this really happening. The current Penitentiary Principles Act provisions on both disciplinary and order measures, including isolation, were adopted almost in their entirety in the consultation document, sometimes word for word.

Not only have the possibilities to use isolation as a disciplinary or order measure been maintained in the draft bill, but the group to which they apply has also been extended: in the draft even immigrants in border detention can be placed in isolation as a punishment. In addition, refusal to cooperate with one's repatriation procedure is explicitly cited as grounds for disciplinary measures. In the endeavour for more 'humane' immigration detention, this is a remarkable and unjustifiable step in the wrong direction.

The authors of the draft bill seem – like the Ministry of Security and Justice staff that Amnesty International, Médecins du Monde and the LOS Foundation talked to – to regard isolation in immigration detention as a necessary management tool. This assumption seems to be an important reason why there has been no attempt to change things. The next chapter demonstrates, however, that it is a misunderstanding that isolation is a necessary part of immigration detention.

7 - How to improve things

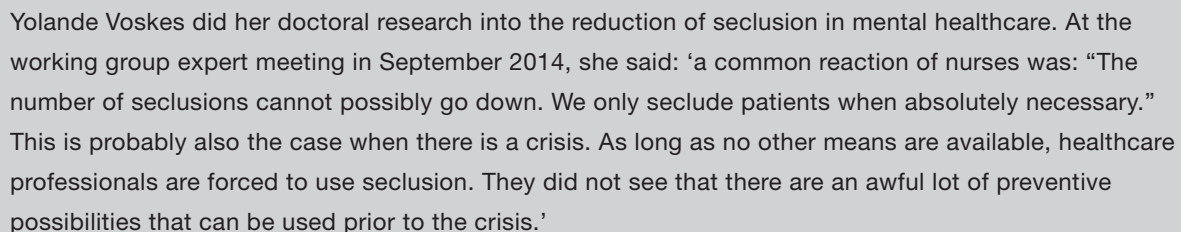
Isolation was used extensively in psychiatry in the past, but it is now controversial. In 2002 research showed that by isolating psychiatric patients, the Netherlands was quite far behind international developments. In some European countries, such as Norway and Denmark, this has long been prohibited by law. In for example England and Sweden, isolation as it is practised in the Netherlands has practically disappeared thanks to other successful policies.¹⁷

MENTAL HEALTH CARE

Several years ago the Dutch Association of Mental Health and Addiction Care (GGZ) modified its policy. It now focuses on the prevention of crises by maintaining close contact with the patient with the slogan 'never leave a sick patient on their own'. Several methods have been developed to give health care professionals the right knowledge and means to identify a crisis ahead of time and take remedial action¹⁸.

The result is that it is less often necessary to place patients in isolation (called 'seclusion' in healthcare). The likelihood of being placed in seclusion in the Dutch mental healthcare system declined by more than 50 percent between 2008 and 2012. If seclusion is necessary, the patient is kept in close contact with healthcare professionals. As a result, the duration of seclusions has decreased by about 50 percent. The ultimate objective is to completely eradicate the use of solitary confinement.

When the decline in the number of seclusions in mental health care came to a halt in 2013, the Netherlands Health Inspectorate proposed an assessment framework, which could be used to investigate whether everything really had been tried to prevent isolation and whether the cases of isolation had been performed according to the rules¹⁹. This is in stark contrast with the lack of review process in immigration detention, where this assessment framework is not used.



Yolande Voskes did her doctoral research into the reduction of seclusion in mental healthcare. At the working group expert meeting in September 2014, she said: 'a common reaction of nurses was: "The number of seclusions cannot possibly go down. We only seclude patients when absolutely necessary."' This is probably also the case when there is a crisis. As long as no other means are available, healthcare professionals are forced to use seclusion. They did not see that there are an awful lot of preventive possibilities that can be used prior to the crisis.'

FORENSIC PSYCHIATRY

Following the example of the GGZ, Dutch forensic psychiatry is gaining experience in the reduction of disciplinary measures. They discovered that punishment, including isolation, led to further escalations. This is being resolved with a more open living environment, in which there is increased contact with staff, growth possibilities, structure, safety and as little repression as possible. This approach has led to greater control of the group, and a safer working environment for staff.

At the Forensisch Psychiatrische Kliniek in Amsterdam specially trained de-escalation staff from the one-to-one team are deployed when there is heightened tension in order to prevent escalation. Colleagues, and also patients can ask for their help. When seclusion is still needed, the one-to-one tutor provides intensive supervision²⁰.

17 Van de Werf, 2002, <http://link.springer.com/article/10.1007%2FBF03071937>.

18 Voskes et al, 2011, *Best practices rondom dwangreductie in de geestelijke gezondheidszorg*, VU Medisch Centrum & GGZ Nederland, (in Dutch) http://www.veiligezorgieterszorg.nl/speerpunt-dwang-en-drang/ggzn_d_d_5.pdf (accessed 20 December 2014).

19 Netherlands Health Care Inspectorate (IGZ), 2012, *Toetsingskader terugdringen separeren*. Utrecht.

20 Helm, P. van der & Stams, G.J., 2013, Conflict en coping bij gedwongen residentiele behandeling. In: Van der Helm et al, *Leefklimaat in de klinische forensische zorg* (p. 234-249). Amsterdam: Uitgeverij SWP.

IMMIGRATION DETENTION IN SWEDEN

Immigration detention in Sweden is achieving good results with a freer regime, which is aimed at maintaining autonomy, responsibility and dignity. The immigrants are not kept in cells, but in rooms to which they have a key. This open living environment also results in greater stability and safety here and therefore in fewer incidents. This prevents escalation, and with it the need for isolation.

When the detention staff cannot handle the situation, they call the police. The immigrant is then detained at a police station. The detention staff pays the immigrant a visit at the police station as soon as possible, to discuss what happened and the possibility of returning to the centre.

Recommendations

The current immigration detention policy can lead to human rights violations and (sometimes severe) adverse health effects. The safety of both detained immigrants and staff would be better protected by making changes. Isolation in immigration detention is anachronistic. The aim must therefore be to eliminate it completely.


Dutch healthcare policy can serve as an example, as well as Dutch forensic psychiatry's practical experiences and successful examples abroad. They demonstrate that it is possible to drastically reduce isolation, and possibly even eliminate it. Amnesty International, the LOS Foundation and Médecins du Monde invites politicians, administrators and supervisors to make a serious attempt to do so. Following the recommendations below would be a huge step forward:

To the government:

- Revoke the legal power to impose isolation as a disciplinary measure in immigration detention centres.
- Take concrete steps, formulated in an action plan, to work on the reduction and eventual elimination of the use of isolation as an order measure; use the framework that has already been established by the GGZ.

To the Netherlands Healthcare Inspectorate and the Inspectorate of Safety and Justice:

- Make the GGZ guidelines an integral part of the supervisory framework in immigration detention.



The report 'Isolation in immigration detention' contains further recommendations for creating the right conditions for the reduction and eventual elimination of isolation in immigration detention. It is available (only in Dutch) at www.doktersvandewereld.org/notitie-isolatie-vreemdelingendetentie

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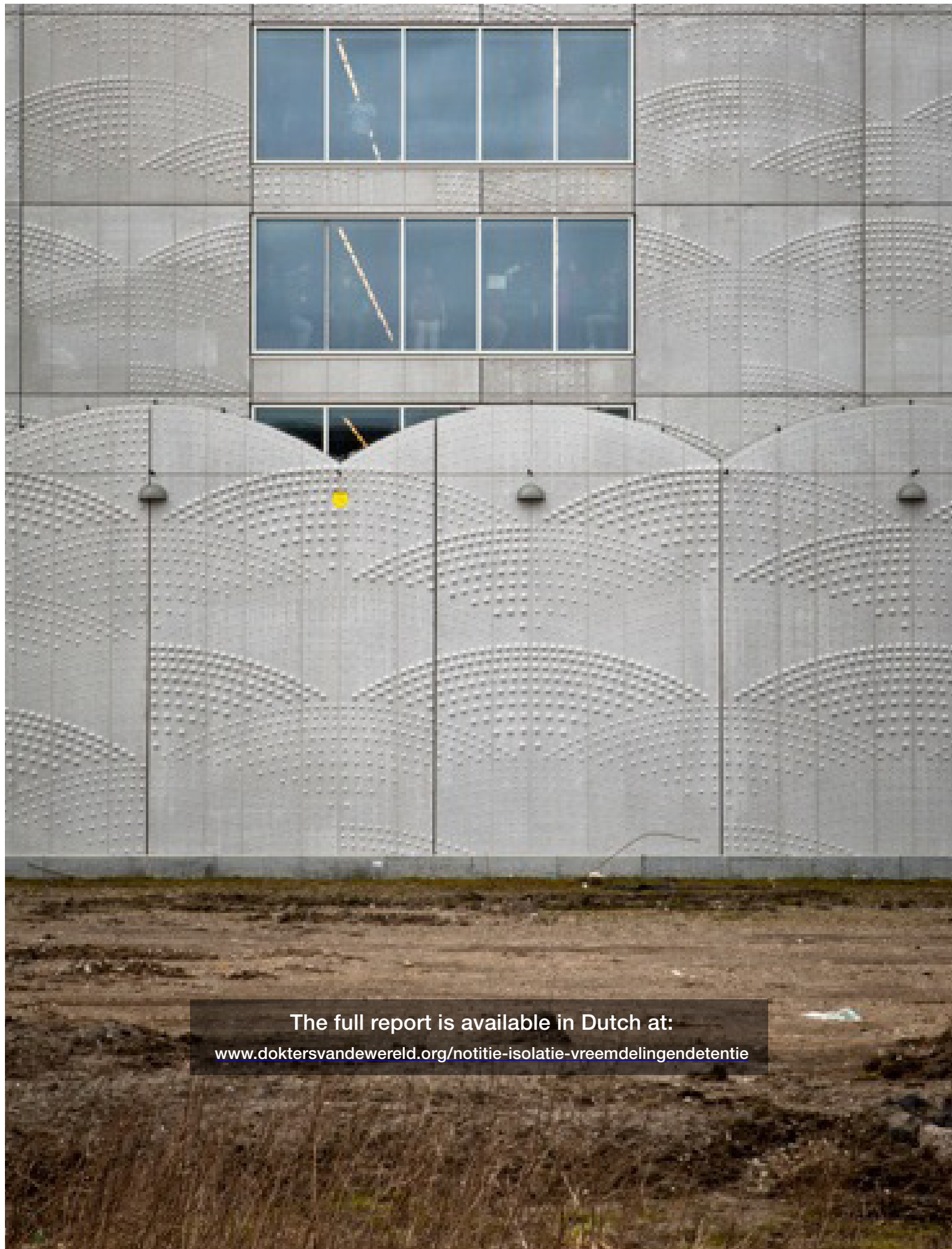
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