Mental Health in Immigration Detention Action Group
Initial Report 2013

Drawing by Lucy Edkins

Medical Justice
seeking basic rights for detainees

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This has been drafted by Dr Hilary Pickles on behalf of an ad hoc group concerned with the mental health of those held under immigration powers in the UK. For the membership and terms of reference of the group, see appendix 1 (page 27). For feedback and further information, please contact Medical Justice at 86 Durham Road, London N7 7DT

Executive summary

1. Around 4,000 people are detained at any one time using Immigration powers in the UK. This is mostly in Immigration Removal Centres (IRCs) but some are in other facilities such as prisons, even though any sentence would have been served. The decision to detain is made at a relatively junior administrative level.

2. Evidence and experience shows that mental illness is the greatest health issue for detainees. The safeguards to prevent the detention of those with serious mental illness are not working. The rate of mental illness is already high in those who are subject to detention, in part due to the stresses in their life journey to that time. Detention serves to increase that mental illness and distress, so that the majority of those studied report significant symptoms. Post traumatic stress disorder, say following torture, is exacerbated by further incarceration. The indeterminate nature of immigration detention adds to the distress. This can include illness at the highest level of severity, such that transfer for compulsory treatment in a mental hospital may be regarded as appropriate.

3. Diagnosis and treatment to NHS standards are expected to be available to detainees, but this is not the case in practice. Many staff have had no training in the identification and management of the mentally ill. The inadequate record system in IRCs, problems with translation and unavailability of family rapporteurs mean even obvious diagnoses are often missed. The treatment modalities on offer in detention are far less extensive than those in the community at large, and the access to and standard of what is available is often poor. There is a crisis of mental health in detention, as demonstrated by the many Court cases where successful action has been taken against the Secretary of State for the Home Office.

4. Transfer of responsibility for the healthcare of detainees from the Home Office to the NHS (Health and Justice in NHS England) provides grounds for some optimism. With time, much of the clinical diagnosis and care should improve. The major changes needed however are to the detention regime itself.

5. We make some practical suggestions for how the system could be improved such that these most vulnerable individuals can have their health protected so they become better able to make a positive contribution, either in the UK or overseas. Detention should not be used for those that have recognised mental illness. A fixed upper time limit for detention would prevent some of the worst abuses. If transfer to mental hospital is ever needed, then afterwards such clearly sick individuals should not be returned to detention. Our proposals could be achieved under existing legal powers and generate great savings for the public purse at the same time as protecting the health of individuals. We also believe it could be done with minimal negative impact on the determination of immigration status and removals, the stated rationale for detention in the first place.

Immigration detention in the UK

The UK contains very many thousands of asylum seekers, failed asylum seekers, irregular or illegal migrants, those who have over-stayed their visas, foreign national ex-offenders and other non-EU subjects with no established right to remain. They are all subject to immigration control and at theoretical risk of removal or deportation if they fail to get established status to remain[8,10].

Although it is still a very small proportion of the total, increasing numbers of migrants are now held, either in immigration removal centres (IRCs) or in prisons even though any custodial sentence has been completed. The numbers have increased in the last decade so shortly there will be up to 4,000 held at any one time, around 3,200 of whom would be in the IRC estate. As well as the 10 main Immigration Removal Centres (IRCs) there are also short-term holding facilities (STHFs) for people who have just been apprehended or who are in the process of being transferred around the detention estate: these do not operate under the Detention Centre Rules and currently have none of their own.

Table 1

IRC/STHF and contractor	Numbers	Contractor	Healthcare contractor
Harmondsworth, near Heathrow	623	GEO Group	Primecare
Brook House, near Gatwick	426	G4S	G4S
Yarl's Wood (mostly women), near Bedford	405	Serco	Serco Health
Morton Hall, Lincolnshire	392	Prison Service	G4S
Dover	314	Prison Service	Prison Service
Colnbrook, nr Heathrow (27 women, others men)	308	Serco	Serco Health
Dungavel, Scotland	217	GEO Group	Primecare
Campsfield, Oxfordshire	216	Mitie	The Practice plc
Haslsar, Portsmouth	160	Prison Service	Prison Service
Tinsley House, near Gatwick	154	G4S	G4S
Pennine House, Manchester (STHF)	32	Reliance	
Larne House, Northern Ireland (STHF)	19	Reliance	
Cedars for families (STHF)	25	G4S and Barnardo's	G4S
Post-sentence in various prisons	936	mostly Prison Service	mostly Prison Service
Current Total in IRCs and STHFs	2,400		
Total	**3,266**		

Most of the IRCs are privately run and others fall to the Prison Service now the National Offender Management Service (NOMS), all under the Home Office Immigration Enforcement Directorate (ex UK Border Agency (UKBA)) (see table 1). The decision to detain is basically an administrative one, made initially at a relatively junior level, pending examination of the immigration case and/or to facilitate removal. Detention is expected to be for short periods only, either at the beginning or end of the immigration assessment. In practice, many cases prove difficult to resolve and many detainees are held not for days, or even weeks but sometimes for months or years. When there are problems with the rapid resolution of the immigration case, there is scope for the Home Office to release the detainee on temporary admission but this is not used as frequently as it should, or the detainee can apply to the immigration tribunal for release on bail: many avoidable obstacles to both types of release are found in practice[5]. Hence many detainees are held in limbo, unclear when and how their life outside will recommence, and where that might be. The men in particular are moved around the detention estate, although the purpose of these moves is often unclear. The net effect however is to disrupt relationships with legal advisors and healthcare staff within the IRCs and to add to the disorientation.

The hardening of attitudes to immigration in recent years has been reflected in policy statements from Ministers and other politicians, generally denigrating

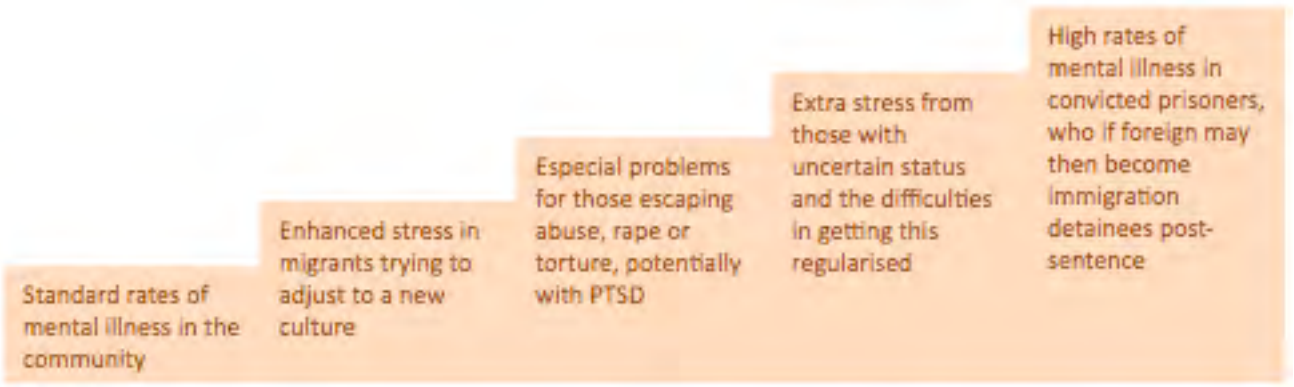
immigrants. The media, especially the right wing media, have exploited existing tensions repeating xenophobic and anti-immigrant comments[71]. Specific proposals emanating from the 'hostile environments' policy group have added to the pressures on immigrants. It is not a good time in general to be without established status. But life in detention, away from family and friends, proves for many even worse than life with uncertain status in the community. This report focuses on the mental health of those detained under immigration powers in the UK.

The prevalence of mental illness in detainees

Mental illness is common in general. Around I in 6 adults in the community were recorded in a survey as having a neurotic disorder[a] in the previous week[34,73]. Most families in the UK have members who have or who have had mental illness, and there is a lifetime chance of needing treatment for a mental disorder of at least 1 in 4[34,78]. Within the UK population, there are some people who are more likely to have mental illness, either because of their genetics or their life experiences and circumstances. Some ethnic minorities, like Afro-Caribbeans with schizophrenia, and Black and Asian men with common mental health disorders, may have higher rates of some conditions diagnosed, with a continuing debate about how much this reflects differential diagnosis and how much a genuine difference in disease prevalence[7,23,38,116]. The rate of mental illness in immigration detainees has to be judged against what would be the normally accepted rate for the UK resident population of similar age/sex and ethnic background.

In practice, there is a "crisis of mental health in immigration detention"[67]. The full range of disorders is present, including psychoses and in particular Post Traumatic Stress Disorder (PTSD) and depression, and at unacceptably high rates. There are several independent factors as to why rates of mental illness are especially high among immigration detainees. Firstly, there is evidence to show all migrants experience some disturbance through leaving their homeland and settling or trying to settle in a different country with a different culture. Secondly those that are asylum seekers are fleeing adverse conditions, potentially abuse, rape or torture, which will have had adverse impacts, potentially severe enough to be classified as PTSD[81,110]. Thirdly those who arrive here without settled status may have constant concerns about their immigration position, some maybe spending months or years trying to avoid detection[4]. Fourthly, there is a well-recognised increase in mental illness in those convicted of criminal offences, and this is especially high in some ethnicities[13,14,89]. People in the UK without permission and foreign nationals convicted of serious offences face removal or deportation[6,15,22]. Foreign national prisoners (FNPs) used to be transferred to IRCs after the end of their custodial sentence (with some exceptions), but are now routinely detained in prison under immigration powers post-sentence. They are likely to have higher rates of mental illness than those who have not been prisoners[6]. So for all these reasons, the expectation is that there will be high rates of mental illness in those immigration detainees as they start detention. This does not mean, of course, that any individual will necessarily be mentally ill, whatever stressors in their life to that time.

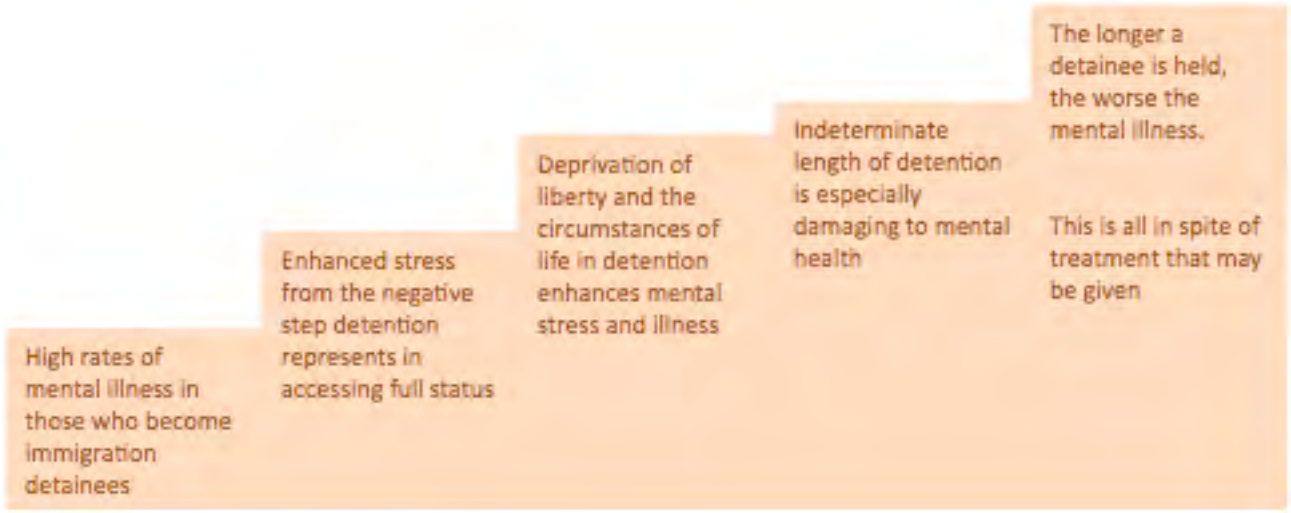
[a] Neurotic disorders in 16-74 yr olds in previous week: phobias, depressive episode, generalized anxiety disorder, mixed anxiety depression, obsessive compulsive disorder and panic disorder. Range from 263.2/1000 in Manchester PCT to 111.0/1000 in Shropshire County



Schematic of rates of mental illness in those who could become immigration detainees

The problems of mental illness however are also liable to get exacerbated whilst in immigration detention[2]. Again, there are several reasons for this. Firstly detention presents a negative step change for the individual in relation to the determination of their immigration status: the theory though not the practice is that detention is used because either (i) the claim can be resolved within a short time period with removal or, in a small number of cases, release soon after (ie in the detained fast track) or else (ii) the end of the process is in sight with removal imminent[75]. Detention often means that the person's story of any abuse has been disbelieved, or on fast track is likely to be disbelieved, with its own negative impact. Removal might be being threatened to a country where persecution has been experienced. Secondly, deprivation of liberty has a negative impact, with its separation from friends and concerns about how the family can manage without the input from the detainee. This is especially distressing for those who had been incarcerated in their home countries, triggering reminders of the original traumas. For those who cannot speak English, there may be few others with whom conversations can be held, adding to the boredom and isolation. Those who are gay have the added stress of dealing with homophobia in detention. Some might find they are expected to share facilities with those who have been deadly political rivals in their home countries. The fluidity of the detainee population, with people being taken for removal, newly arrived in detention and transferred to other centres adds to feelings of stress and uncertainty. The presence of so many others with overt mental illness is distressing in itself. The net impact of this increasing frustration and isolation is exacerbation of existing mental illness and generation of mental illness de novo in others[17]. Thirdly, a significant issue for immigration detainees unlike those serving a defined term prison sentence is that there is additional uncertainty, with no firm end in sight. This indefinite detention, like indeterminate prison sentences, has been shown to enhance mental illness greatly[64,84,90]. Fourthly, even though short periods of detention can have a marked effect[19], the longer detention continues the greater the problems with mental ill-health[37]. Whilst access to treatment in immigration detention should be able to ameliorate some of the worst symptoms, this is generally regarded by those with wider experience as being less effective than that available to those with equivalent symptoms in the community at large[103].

It is not easy to give accurate figures for the rates of mental illness in immigration detainees. The sort of detailed studies that have taken place in the prison population have not been done, and the situation is more fluid in any case, both for the individual detainee who may be present at any one IRC for only a short time and for detention policy, that has shifted considerably in recent years. There have been attempts to undertake robust research, and more is underway (see appendix 2), but to date there has been nothing that matches the highest standards of research design with well-described assessment in fully-representative samples of detainees and with follow-up to identify incidence and persistence. This is not compensated for by good routine clinical data – there is no equivalent for the detention estate for the prescribing data available from every NHS GP practice, nor for the outpatient, admission or activity statistics for those receiving specialist NHS care in hospital or in the community. Other routine statistics, such as numbers self-harming, are unreliable since it seems there is no common interpretation across the detention estate of what to record[79].



Schematic representation of increasing rates of mental illness in immigration detainees

Academics that have accessed detainees have reported high rates of illness, the most robust studies to date being that led by Katy Robjant[100] and more recently by Mary Bosworth[11]. In the latter study, using a standardized instrument, over 80% of the detainees studied were classified as having depression. These and other UK-based studies are reflected in table 3 in appendix 4. Mental illness within prisons is recognised to be a major problem, and especially for those on remand, yet some describe an even worse problem within IRCs[21,60]. Mental illness severe enough to warrant section appears far more common than might be expected for the size of the population, but even when requests were made on behalf of the then body responsible for commissioning the care, no quantification could be provided[85]. Information on actual numbers transferred from IRCs under Mental Health Act section has been requested by the group under the FOI to the Home Office, MoJ, NHSE and a key NHS provider (see appendix 10). The responses from the NHS flushed out continuing confusion over commissioning responsibilities, and a suggestion that at least in the main receiving hospital for male detainees, this may have contributed to fewer cases being admitted this year. When responsibility for prison health care transferred from the Home Office to the DH/NHS there was a national needs assessment that flagged up the high rate of mental illness[65]. There has been no such work on immigration detainees for this transfer of responsibility, though some local work in need of central collation, all of which shows mental illness high on the list of problems[16,32,85,87,105]. It is difficult to see how the right quantum of healthcare can be commissioned in such circumstances.

The Home Office have not welcomed scientific study and much information on the UK situation is mostly anecdotal or limited in scope[3,4,6,11,12,16,21,35,67,88,99,100,110,118]. Appendix 4 provides selected quotes from various official inspectorate and similar reports that have been critical of the current situation, quotes about the experience of individual detainees, and highlights from the published papers. Work that has been done suggests mental illness or distress is very common indeed, and the experience of organizations such as Medical Justice backs this up. This is matched by overseas experience. There are extensive publications on detainee healthcare from Australia, all showing a great excess of mental illness and distress[9,20,36,74,82,108,109]. The same basic findings are seen in other countries: detaining vulnerable people in a foreign land is very damaging to their mental health[2,18,19,37,56,61,75,80].

Responsibilities for Healthcare

Until August 2014, the overall responsibility for the health and well-being of immigration detainees will remain with the Home Office, who discharge that responsibility through contracts made by the UKBA/Immigration Enforcement.

Most prisons and some detention centres fall to the Prison Service, where for over a decade the health care provision has been delivered by the NHS. For the other IRCs, as with the custodial care, in-house healthcare is the responsibility of private contractors (see table 1). Until April 2013, in England the local Primary Care Trust (PCT) commissioned any needed hospital-based healthcare for immigration detainees, with an uncertain and variable arrangement for the provision of any secondary-level services delivered at the IRC site. PCTs were disbanded in April 2013. The Home Office/UKBA has also started the process of transferring healthcare responsibility for primary healthcare to the NHS, mostly to the Health and Justice team within NHS England (NHSE) but a process that was expected to start in April 2013 has been delayed for over a year. Responsibilities as they apply to the mentally ill are outlined below. Most immigration detainees do not present a risk to others and so when under MHA section do not need to be in secure placement, which are usually used only by those from the criminal justice system: those places are commissioned by the specialist commissioning team of NHS England. The area and local NHS E Health and Justice teams should be commissioning any in-patient places needed in mental health hospitals, whether for detainees under section or as voluntary patients. There has been some confusion over responsibilities, however (see appendix 10).

Table 2

Who Pays ? Before April 2013	Who pays ? Mentally ill resident in England	Mentally ill resident in England IRCs not under the Prison Service
Primary health care from GP	PCT	UKBA
Community care	PCT/LA	PCT/LA
General hospital care, specialist services, A & E and ambulances	PCT	PCT
Community support for those post MH section (s117)	LA	LA/PCT
In-reach psychiatric care and counseling	n/a	UKBA or PCT or none or uncertain/variable
Places under MHA section	PCT	PCT

Who pays ? As at December 2013	Mentally ill resident in England	Mentally ill immigration detainee in England
Primary health care from GP	CCG	NHSE Health and Justice/HO[b]
Community care	CCG/LA	NHSE Health and Justice
General hospital services A & E and emergency ambulances	CCG CCG	NHSE Health and Justice[c] CCG
Community support for those post MH section (s117)	LA	LA/CCG
In-reach psychiatric care and counseling	n/a	Home Office or NHSE Health and Justice or uncertain/variable
Secure places under MHA section	NHSE (specialist services)	NHSE Health and Justice[d]

[b] NHS E Health and Justice in the IRCs under the Prison service/NOMS, and also in the others from September 2014, HO until then

[c] Not until April 2014 for those in Brook and Tinsley House and Campsfield, according to the regulations [SI 2996 2012], but no one else can pay for this in the meantime

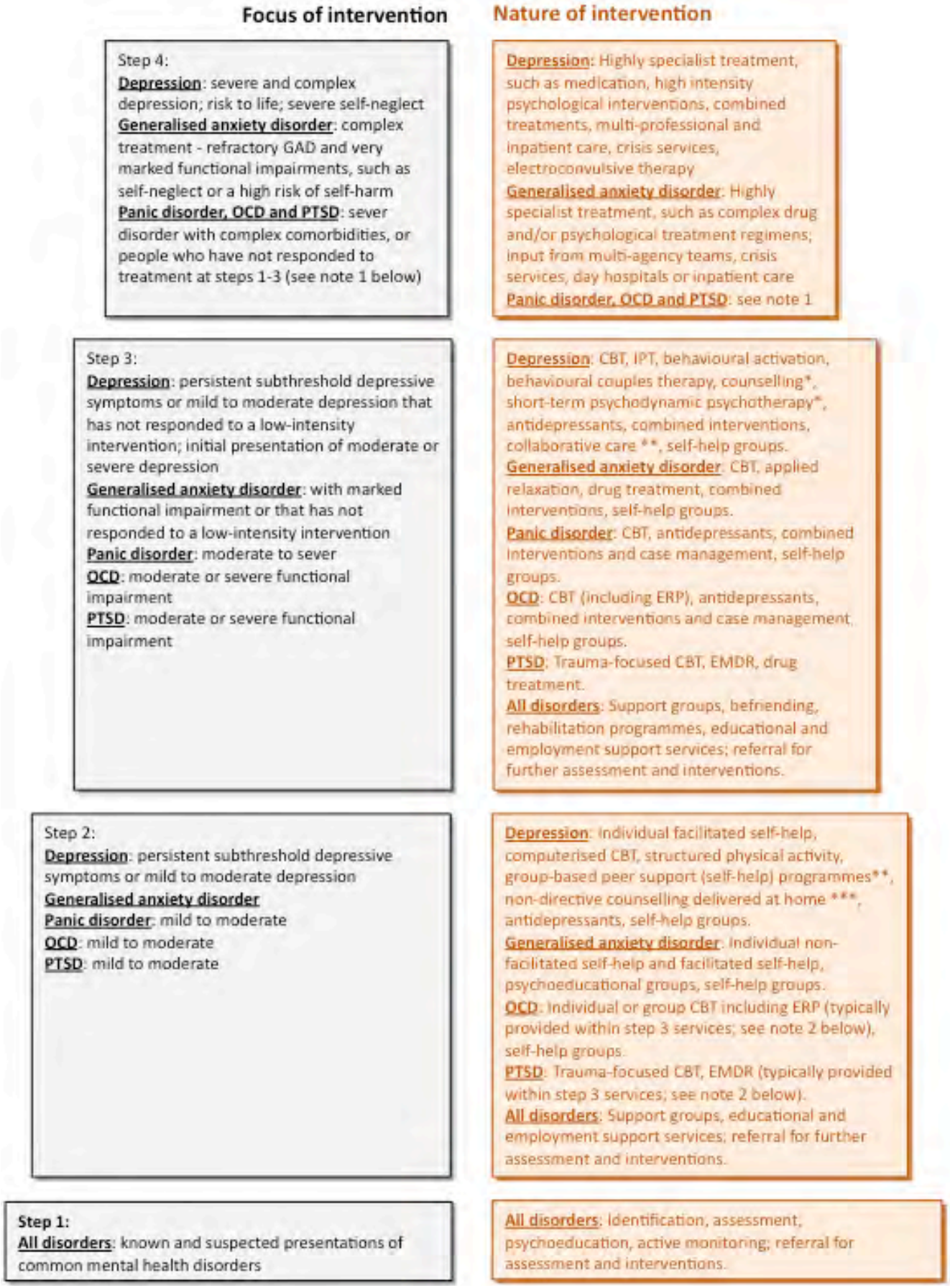
[d] NHSE Health and Justice, except for secure placements for those involved with the Criminal Justice system (which should not include any current detainees) which fall to NHSE specialist commissioning

The expectation is that healthcare matches standards in the NHS. In relation to mental health provision, there is explicit comment in rule 24 of the Detention Centre Rules (Healthcare Operating Standards) - 'detainees must be treated by appropriately trained healthcare professionals in line with national standards and practice', ie to an NHS equivalent standard [111,114].

For those that are not detained, there are many treatment options. The majority of mentally ill people receive their diagnosis and treatment from their GP, but even so very many – around 1 in 32 in England at any one time – are also in contact with specialist mental health services, a third of these being over age 65[70]. The great majority of specialist mental health care is provided in the community, with the numbers needing admission to mental health beds falling year-on-year: currently under 8.4% of the 1.27 million people using specialist mental health services are admitted to hospital[70]. Of those who are in hospital, 42% have been subject to the Mental Health Act at some point in the year, the rest being voluntary patients, but the one-day census on which these data are based over-emphasises those who are long term residents, such as many of those in high secure care[70]. Black and minority ethnic patients are over-represented among mental health patients in general and in those admitted to hospital[7,23]. At the last count, there were under 19,000 occupied mental health beds for all adult ages in England. National policy and professional good practice is to keep the mentally ill out of hospital, with the option of supervised community orders when treatment has to be enforced.

The responsibilities as outlined in the table above are as at December 2013, but proposals have been consulted upon that would restrict free access to the NHS for those who have not had settled status for a year. Although the proposals would leave free treatment for immigration detainees, they introduced many additional difficulties for this group, before and after detention, and also for the mentally ill from ethnic minorities who could be confused with those without the necessary immigration status. They also appeared completely unworkable in practice as well as over-expensive, counter-productive and discriminatory. The response from this group to this consultation is in appendix 8, arguing against the proposals but failing that, makes the case for a complete exemption from any charges for mental health diagnosis and treatment.

NICE Stepped-care model showing steps 1 to 4 for people with common mental health disorders



Note 1: The NICE clinical guidance on panic disorder (CG113) and OCD (CG31) uses different models of stepped care to the 4 step model used in the NICE clinical guidance on depression (CG90, CG91) and generalised anxiety disorder (CG113). The NICE clinical guidance on PTSD (CG26) does not use the stepped care model. People with panic disorder, OCD or PTSD that has not responded to treatment at steps 1-3, or who have sever disorders and complex comorbidities that prevent effective management at steps 1-3, should receive specialist services at step 4, according to individual need and clinical judgment. The principle interventions at step 4 are similar to those listed for depression and generalised anxiety disorder, with the exception that electroconvulsive therapy is not indicated.

Note 2: The NICE guidelines on OCD (CG31) recommends that people with mild to moderate OCD receive individual or group based CBT. The NICE clinical guidance on PTSD (CG26) recommends that people with mild to moderate PTSD receive trauma-focused CBT or EMDR. These interventions may typically be commissioned from, and provided by, trained, high-intensity therapy staff in step 3 services.

* Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression.

** For people with depression and a chronic physical health problem.

*** For women during pregnancy or the postnatal period.

Key: CBT - cognitive behavioural therapy; EPR - exposure and response prevention; EMDR - eye movement desensitisation and reprocessing; OCD - obsessive compulsive disorder; IPT - interpersonal therapy; PTSD - post traumatic stress disorder.

From NICE[78]

The current problems

There are very many problems with immigration detention at present, and what follows just highlights those of most concern in relation to mental illness.

For a fuller listing, see the briefing from BID and AVID[67]. For a flavour of the impact possible on individuals, see the quotes in appendix 4

A. Adequacy of diagnosis and treatment

Healthcare staff within IRCs have to work in a difficult environment, often with inadequate information and support, and split loyalties to their patients and to their immediate colleagues who maybe more concerned with custodial matters[83]. The constant description by Home Office case-workers of psychotic symptoms as manipulative, for example, may well influence clinical behaviour, especially for those without strong line management support. At present, unlike with standard general practice, clinical support staff do not report to the GP, meaning it is unclear who has the overall clinical responsibility. This is especially difficult when the service is provided by GP locums, as currently at Harmondsworth[16]. Much clinical effort is diverted to induction checks which do not provide the most suitable occasion to delve into mental health stresses.

The doctors in the IRCs are expected to be able to diagnose and prescribe as their colleagues do outside, but are handicapped in this by the frequent unavailability of previous health records, the transient nature of their clinical engagement with the detainee, maybe language difficulties or the uncertainties of translation, and the lack of intelligence from family and friends that is usually so helpful in psychiatric diagnosis. Although there may be mental-health trained nurses available in the IRC, they are often used in a generic nursing role. The treatment options are much more limited than available outside, with potential over-reliance then on GP-prescribed psychoactive medication, maybe with also nurse-administered alternative medicines – Kalms being a firm favourite in Yarl's Wood, in spite of the lack of any evidence base for efficacy. Some but not all IRCs have access to counselors, but none are able to provide the full range of talking therapies as would be expected in the community. There may be visiting psychiatrists, but they have the same difficulties as the IRC's own doctors in delivering the same standard of diagnosis as would be possible in an NHS clinic. Only the privately-engaged psychiatrists, like those brought in by Medical Justice, seem able to have the detainee's confidence and the time to explore the complex issues that may apply, for example in relation to previous abuse.

In some cases there may be unacceptable delays to see the 'in-house' psychiatrist and unacceptable barriers for external psychiatrists to visit[97]. The expected training in mental health may not take place, even for healthcare staff. It would not be surprising if the response to inadequate facilities to provide clinical care to the expected standards is for the responsible clinician to deny or shrink down the problem, so the treatment provided better matched the 'diagnosis'. The consensus is that although the need for good mental health care is greater for those in detention, to date the ability to deliver this has been less. In some notable examples, that care has failed dismally (see table 2 in appendix 4).

The particular needs of those with PTSD are described in the position statement from the Royal College of Psychiatrists (appendix 5)[103]. These needy individuals are likely to find the detention regime aggravating to their disorder yet 'the treatment of PTSD requires specialist psychological intervention in a setting conducive to a sense of safety and to a growing sense of trust towards the therapist'. As is explained, the staff and facilities in IRC are unable to provide what these patients need. The College statement also explains how the regime within IRCs also serves to exacerbate depression and psychosis, and how the staff and facilities cannot match what is available to NHS patients in the community[103].

To access more expert help and support for the mentally ill, as would be found from community-based NHS mental health services, the expected option appears to be escalation to compulsory admission to hospital. Used to what the MoJ does with prisoners, the Home Office transfers detained people as if under section 48 of the Mental Health Act, even though there are no formal powers to transfer people detained under section 36(1) of the UK Border Act 2007 under section 48. So for the subset of detainees held under s36(1), it seems

section 2 or 3 of the Mental Health Act are being used instead even for those going straight to hospital. However, were the detainee released rather than transferred to hospital, the treating team could chose the least restrictive environment – as a community or voluntary inpatient perhaps, with compulsion only used once lesser options have been considered. It is noted that temporary release would also transfer the funding responsibility for subsequent healthcare from the NHSE Health and Justice team to the local CCG.

It seems overall that the treatment available within detention for mental illness does not reflect the best practice available in the community, where the expectation is that there is a wide range of treatment options on the stepped care model (see diagram from NICE)[78]. It appears that the mentally-ill detainee can access treatment options only at the lowest and very highest steps, but not at the intermediate steps. The overall view is that the diagnosis and treatment of mental illness is unacceptably substandard within immigration detention[88,103,118]. Many of the comments and quotes within appendix 4, and the Court cases that lie behind some of them, reveal missed opportunities to help vulnerable people who were in no position to help themselves.

B. Identification of the especially vulnerable groups including mentally ill

Experience from individual cases show the compulsory nurse-led healthcare screening assessment has often proved incapable of identifying even those with previously diagnosed mental illness. It may take place with detainees after they have traveled for many hours at unsocial hours and the tick-box approach adopted is ill-suited to the exploration of sensitive issues around mental health. It seems no useful collated data becomes available from this screening. It may or may not be followed by GP screening within 24 hours (rule 34 of the Detention Centre Rules).

Rule 35 asks that 'the medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continuous detention'…with specific mention of suicidal ideation, victims of torture, and mental conditions[113]. This should provide a safeguard for the mentally ill, but in practice the system fails. The rule 35 forms are often not initiated when they would be appropriate, and then the majority appear ignored by the UKBA anyway[110,59]. The IRC doctors, and the Immigration Enforcement /UKBA misrepresent the data they do have – see Appendix 9 for a letter from this group to correct a parliamentary question on this topic and which provides more information on this issue. The truth is we do not know even the number of cases when the treating doctor from the IRC believes continued detention is potentially damaging to mental health, let alone all those overlooked by the doctor.

Proposals for an audit of rule 35 have been circulated by the Home Office recently, the latest attempt to audit this process, the results from previous audits having been 'lost' or proven unsatisfactory and shown the system not to be working. A worrying development is the emphasis on the clause that relates to torture, with apparent disregard of the clauses relating to mental health and risk of being injuriously affected by detention. Audit of the handling of the rule 35 process would be incomplete in any case without the clinical audit element, ensuring there is appropriate detection by the IRC doctor. Although Rob Whiteman, a senior UKBA official, did not appear to know this, only a registered GP is able to sign these forms[53]. That makes all the more shocking the frequent disregard by junior case-workers of the GP's clinical judgment, and argues that the doctors should be encouraged to make a stand more often. The transfer of overall healthcare responsibility from the Home Office to the NHS may strengthen the hands of the medics and increase tension if their advice continues to be ignored[83].

As in prisons, there is also in detention centres a formal process for assessing and monitoring those thought to be at risk of self-harm – the ACDT – assessment, care in detention and teamwork. Initially this falls to custody rather than healthcare staff and underlying mental illness may not be recognized. In some cases 'Behaviour Management Plans' are drawn up – often they focus on containment and make use of disciplinary sanctions such as the use of isolation. They are understandably felt as punitive by detainees.

C. Impact of detention and indeterminate detention on mental health

The consequences of the detention of the mentally ill are many-fold and include:

- Continued deterioration in mental health, up to and including complete withdrawal, self-harm, food/fluid denial and suicide
- Heartache for those close to the detainee
- Upset for other detainees
- Frustration for those expected to provide care, knowing the best treatment would be release from detention, an administrative decision usually denied
- Longer recovery period for the detainee once released from detention
- Delay in resolving immigration status issues, especially once mental capacity is lost
- Potential loss of talent useful to society here/overseas
- Added costs for healthcare (Home Office and/or NHSE), for the Home Office from delayed decision-making, for the custody provider from the more challenging detainees, and eventually the taxpayer
- Positive consequences only in a 'hostile environments' mindset which would regard any negative ruling on human rights grounds as a badge of honour, irrespective of any damage to the UK reputation as a decent place

Further expert comment on the impact of detention on mental health is given in appendix 5 from the asylum working group of the Royal College of Psychiatrists[103]. This covers the issues of most relevance to Court rulings on mental health in detainees.

Many of the individual responses to continued detention could be seen as a normal/expected reaction to the exceptional circumstances, so there should be no assumptions that even the most sick individuals could not be able to become useful assets to society were they treated well and released. The longer the detention, the greater the harm[37,61,109]. For those with PTSD following previous torture or abuse, the period of recovery could be extensive, and be delayed by this 'second torture'[110]. Detainees are held in an 'indefinite detention', not knowing how long they will remain locked up, and this adds to their difficulties.

In spite of what is said to be the ready presence of the in-house healthcare staff and the treatment they can offer, the overwhelming view is that continued detention is associated with deterioration in mental health[29]. Hence detention is no place of choice for those that are mentally ill. This then is at variance with the statutory ground for the refusal of bail which allows for the Tribunal to judge 'the applicant is suffering from mental disorder and continued detention is needed for his interests or for the protection of others[5,112]. In refusing bail on the grounds of mental disorder, any tribunal would in effect be condemning the detainee to a worse clinical outcome than would be possible if the full range of NHS options were available as in the community, assisted by the undoubted benefits to mental health generated by release in its own right. For more debate on this topic, and why great care should be taken with any assumptions that detainees would be better off in detention, see the recent report from BID[5]. The issue of 'protection of others' is a red herring based more on ignorance than evidence, and false fears about this should play no part in bail decision-making. All the evidence suggests the mentally ill are a far greater danger to themselves than to others, and the days of locking up swathes of the mentally sick has quite properly passed into history. For the very few mentally ill people who do present a significant and continuing risk to others in spite of treatment, the right place would be a secure mental unit, held under the Mental Health Act.

D. Section under the Mental Health Act

At what should be the most severe end of mental illness, detention under the Mental Health Act is being used on detainees, although it seems even the official inspectorates are unable to access data on the numbers[46]. For recent attempts to access information on this issue, see appendix 10. The advantage of sectioning is that it permits compulsory treatment of mental illness, but for immigration detainees it

appears mostly to be used to enable access to specialist care which for others is available in the community or as a voluntary inpatient. IRCs are not authorised places for holding the sectioned, so transfer is needed to facilities either in the NHS or otherwise used by NHS patients. Currently there is acute demand for inpatient mental health beds[39]. There have been tensions when local facilities in short supply have been used for immigration detainees, and when there are competing calls for limited places, detainees regarded as already being in a place of safety may have had to take second place[43].

Another contentious issue concerns whether discharge from section can be to the community or whether, as now seems to be being suggested by a recent case and the latest policy on section 48 transfers, only within the 'closed loop' and back to the IRC[27,57]. If these severely sick individuals are unlikely ever to be fit for removal or deportation, or able to participate in their immigration case being resolved, delaying the inevitable release serves no purpose. Of course, had release taken place earlier in the illness, the further deterioration and MHA section may never have been needed.

E. Detainees within prisons and STHFs

A few years ago, concern about the non-deportation of foreign national prisoners post-sentence led to the resignation of a Secretary of State (Charles Clarke). Ever since then, foreign national prisoners have been seen as a highly political issue, with the default position being deportation for all non-EEA foreign nationals who receive sentences of a year or more. This is even if the sentence arose from the possession of false identity papers, which might be seen as an unavoidable component of escaping from persecution, or from the behaviour associated with destitution. Until a few months ago, on completion of their sentences most foreign national former prisoners were transferred to IRCs, where they became the majority in some detention centres like Colnbrook, even though there was a working limit of around 35% of ex-offenders for the estate as a whole for reasons of control. In recent months there has been another unannounced change in policy, with the effect that foreign nationals are no longer being routinely transferred to IRCs at the end of their sentence but instead continue to be held in prisons. In September 2013 there were 936 people across 80 prisons in this position and the number continues to increase. Especially when release was anticipated after completion of the sentence, being kept on in prison indefinitely at this stage has a major impact on individuals, including on their mental health[22]. There is no evidence the needs of the individual are considered at all.

Although most of those held under immigration powers in prisons have served a custodial sentence, there are others who have never been so convicted. Healthcare provision is generally better in prisons than IRCs, but in other ways prisons can be more difficult for detainees. Although detainees in prisons are supposed to be treated as remand prisoners with a more relaxed regime, they may in practice be asked to sign a disclaimer to say they are willing to forgo those rights. Held among and under the same regime as serving prisoners they are not allowed to hold a mobile phone, as they could in an IRC, and may be locked in their cell for many hours during the day as well as at night, making phone contact with legal advisors and family almost impossible. There are no immigration advice surgeries laid on in prisons by the Legal Aid Agency, as there are in all IRCs, and financial disincentives operate to stop dedicated specialist legal aid firms visiting prisons with small numbers of detainees. Access to independent doctors may be difficult. Significantly, although an equivalent system applies for the identification and monitoring of those thought to be at risk of self-harm, some of the other safeguards do not apply in prison. There is no direct equivalent of the duty to report to the Home Office concerns that a detainee may be a victim of torture (rule 35(3) of the Detention Centre Rules), for example, although the Prison Rules ask for the governor to be alerted to those prisoners where continued imprisonment is likely to be injurious to health[91].

Short term holding facilities (STHF) operate outside the IRC rules, meaning again they have no equivalent to rule 35 although for Cedars at least, they are said to work 'within the spirit of rule 35'. Critics of the process explain that the perfunctory assessment soon after arrival in the UK prevents a full assessment of claims for asylum and is especially unsuited to those who are vulnerable, say through mental illness or stressed from their experiences to date.

F. The international position

Attitudes to irregular and other unapproved migrants varies internationally, with some countries accepting millions crossing their borders to escape conflict (as now seen in countries bordering Syria) and others being as difficult as possible to act as a deterrent. Australia and the USA combine a restrictive policy with some openness for academics to describe the impact of detaining immigrants, and that literature provides graphic demonstration of the impact of detention on mental health, even for those that were not ill before being detained[74,80,82].

There is wide variation across Europe, in spite of many common policies. Recently the Receptions Conditions Directive was agreed: even though this applied only to asylum seekers, the UK did not opt in[29]. Under article 11(1), this Directive states 'the health, including mental health, of applicants in detention who are vulnerable persons shall be of primary concern to national authorities'. Article 15 of this directive limits immigration detention to 6 months (with limited scope for extension), which provides a welcome safeguard against the adverse impact of long term and indefinite detention on mental health. In not opting in, the UK is denying these safeguards to those it detains.

That many other nations live with this restriction shows how the UK is out on a limb. However, the UK is not the most harsh in Europe in its handling of migrants, since the situation in Greece is appalling[31,62]. It is a matter of shame that the UK chooses to associate itself with the worst treatment of vulnerable migrants rather than the best, whatever the apparent popular support for xenophobic politics. As with the rest of Europe, the UK is party to the European Convention of Human Rights, though frequent political noise is made about renegotiating this.

G. The political climate around immigrants

There has been a general hardening of attitudes to immigration in recent years, fuelled in part by the financial crisis and the rise of politicians such as those from UKIP. Since this group started its work on mental health, this trend has continued, thanks in part to the output of the 'hostile environments' policy group in government. Many comments against immigrants have been made by politicians and amplified by the right-wing media[71]. There is a general move to present immigration detainees as criminal[1]. Specific proposals have recently been made to restrict the access of non-settled immigrants to certain public services.

Potentially most devastating for the group of immediate concern to the MHIDAG were proposals to limit legal aid. Many of the abuses by the British authorities exposed by the Courts could have remained hidden had legal aid not been available, and vulnerable and mentally-ill detainees remain incarcerated or have been removed from the UK despite having a viable and arguable case to remain. Detailed arguments against the initial proposals for legal aid were put forward from this group and are reproduced here in appendix 6. In the light of overwhelming opposition, the original proposals were subsequently revised. However, many problems remained, with the implications being considered by the Joint Committee on Human Rights. The submissions from this group to that enquiry are reproduced at appendix 7, covering the changes still being proposed to both legal aid and judicial review.

Further proposals from the Home Office and the Department of Health (DH) were subject to a short consultation over the summer holiday. Those most directly relevant to the interests of this group were issued by the DH, which proposed to leave those who become immigration detainees without access to NHS services both before and after any period in detention, unless they had the means to pay. The MHIDAG considered these proposals unfair, unworkable, unethical, discriminatory, damaging to the health of those concerned and to contain built-in perverse incentives. As damage limitation, we suggested that diagnosis and treatment of mental illness and physical illness in the mentally ill could be added to the automatic exemptions from charges for all, as with communicable disease. But overall we opposed the proposals – for our response, see appendix 8.

H. Accountability, monitoring, transparency, inefficiency and cost

As might be expected when things are not going well, there is central denial and withholding of information, alongside failure to release information or even to collect it. The more detention-related provision that is delivered by private sector bodies, the more that aspect of detention is protected from the FOI and by commercial confidentiality, and the greater the difficulty in finding out what is going on. Lack of information pervades the system, even for those who have official status, like the IMBs and HMIP and now the NHSE. Parliamentary committees, external inspectorates and others may well make negative comments, but the situation fails to improve[44,47,52].

The UKBA has been described as 'unfit for purpose', a 'troubled organization with a poor record of delivery' and as a place where 'catastrophic leadership failure is no obstacle to promotion'. The new Immigration Enforcement Directorate is struggling like the UKBA before it with political expectations that go beyond what the budget can deliver.

Privatisation/outsourcing may appear to reduce some costs at least in the short term, but real cash-releasing savings may be elusive and when present, reflect no more than cost-shifting to others. Squeezing staff costs leads to under-trained employees on low wages (such as the overt racists involved in Jimmy Mubenga's death) and not enough of them for the numbers of detainees they are expected to supervise. The NHS will soon realise it is paying over the odds for the treatment, perhaps under section, for those where a simple administrative process by another government department, e.g. release to the community on Temporary Admission, would be likely to improve symptoms for the individual and reduce overall treatment costs for the NHS. Other excess costs in the current system come from the need for additional custodial staff for the disturbed and ill, and the payment of damages to compensate for unlawful detention.

Frustration must be building up for the custodial staff expected to deliver the impossible, as well as among detainees who encounter difficulties in progressing their immigration claims, and the healthcare staff who are expected to pick up the pieces as detainees are damaged by the system. The complaints system means no wrong-doing gets admitted to and so no lessons are learned. The system is in crisis, with little scope for improvement without a change in policy.

Detaining the mentally ill is counter-productive in very many ways, for the individual, for those trying to determine the right response to immigration applications, for those expected to keep the peace within IRCs, and for those trying to provide clinical care. It would require no change in law to implement very many of the recommendations from this group (see later) and far from increasing costs to the public purse, they would all reduce those costs. To relieve the current pressures on the Immigration Enforcement Directorate, the adoption of our proposals should be a no-brainer: failure to do so reflects badly on those that are responsible for continuing the current policy. Some ill-defined political advantage appears allowed to over-rule the human and financial costs of continuing to damage the most vulnerable.

Opportunities

The current situation looks bleak, but there are grounds for some optimism.

a. Transfer of healthcare responsibilities to the NHS

In England the responsibility for the commissioning of healthcare for people detained in IRCs is in the process of transferring to the NHS and this has been welcomed[86]. As was found when prison healthcare transferred from the Home Office to the NHS, it provides an opportunity for a new look at how services are delivered which should lead to improved standards. In the short term the same contractors will be providing the on-site clinical care, but even here there must be a subtle shift in allegiances among the health professionals leading towards the normal ethos found in the NHS. New contracts based on new service specifications should enable more services to meet the expected NHS standards, and the current confusion over accountability for secondary-level mental health services provided in the IRC setting should get resolved. In the future the payer should always be the Health and Justice team in NHSE.

Clinical teams within IRCs will benefit from commissioners with experience of healthcare in other secure environments and from peer support from professional groups, like the Secure Environments Group (SEG) of the Royal College of General Practitioners (RCGP). Dual or shared appointments and exchange of clinical staff with teams in the wider NHS should support IRC clinicians in their professional development. There are already proposals for electronic records which will make a great difference to practice, albeit quite a wait before this gets delivered fully in all IRCs. Healthcare complaints should find a new route, facilitating learning from past events[25].

b. More and better research and audit data

There is much we do not know about the impact of detention on mental health in the UK. There are data in the system, but they are in disarray and remain inaccessible to outsiders. With a will, a national needs assessment could be undertaken or collated from the many local ones, looking for example at interactions with secondary care psychiatrists, mental health-trained nurses and counselors, and prescribing. A retrospective audit of those who have been subjected to section has been suggested, in order to identify and then help these people at an earlier stage in the pathway[85]. There might even be a way to allow useful data to be identified from the many induction checks, with their routine questions about mental illness. With time, the NHSE should be able to produce routine data on those receiving healthcare whilst detained, provided this is identified separately from the care received by the others that fall into their remit. A costing study from the NAO is overdue and could demonstrate the savings that could follow from a more humane policy in relation to the mentally ill and indeed the relatively inefficient contribution of detention to immigration decision-making. Estimates could be made of the healthcare savings possible were those who do eventually receive leave to remain no longer so damaged by extensive detention[115].

There is a need for more formal research, ideally a controlled prospective study exploring the alternatives for handling mental illness, also including outcomes relevant to the immigration status. Ongoing or proposed research known to this group is listed in appendix 2. There is much more that could and should be done, though already the evidence is good enough to justify substantial shifts in the current policy, based on robust evidence from overseas and supportive or anecdotal evidence from the UK. All this however may be based on a fallacy, that somehow public policy is evidence-based. Much recent experience suggests that is not often the case.

c. Consensus on inappropriateness of the detention of the mentally ill

There came a moment when the continued detention of children was agreed to be inappropriate, albeit that detention continues under a new guise. There is much agreement on the inappropriateness of the detention of pregnant women[69]. In those cases the numbers were small: the same could not be said in relation to mental illness. Nevertheless, we need to reach the same position in relation to the mentally ill detainee as we now have with children and hope to have with the pregnant. These people are especially vulnerable and such detention is inappropriate. Most importantly, it is not mandated by the Courts nor by any law (Parliamentary legislation or otherwise) so there are no formal barriers to the implementation of the changes we advocate. The sums that could be saved could more than compensate for any perceived cost, political or otherwise.

The increased interest in this topic suggests the time may be ripe for significant movement. Those who have made adverse comments in relation to the current practice have included a parliamentary committee, the Courts, the inspectorates, many NGOs and influential individuals[26,28,33,35,48,52,57,60,63,64,67,68,86,88,103,106,110]. The briefing paper from AVID and BID in May 2012 provided an eloquent exposure of the untenable 'mental health crisis in immigration detention'[67]. The financial crisis for the Home Office Immigration Enforcement Directorate and the transfer of healthcare responsibilities to the NHS provide added impetus. The moves we suggest should both improve health and save costs and we believe can be taken without negative direct impact on the removal program, and help demonstrate the government's commitment to human rights.

Sentinel Court cases and recent legal developments

There have been some important recent rulings that impact on the detention of those with mental illness. They are more expertly described in a recent paper so only the headlines are given here[107].

There was a judicial review of the lawfulness of the detention of HA, a Nigerian with serious problems with mental health, which involved debate on the lawfulness of a change in policy. Previously the guidance said that 'the mentally ill would normally be considered suitable for detention in only very exceptional circumstances'[54]. This had been subsequently amended to state 'those suffering from serious medical conditions which cannot be satisfactorily managed in detention' are 'normally considered suitable for detention in only very exceptional circumstances' [55]. There was no consultation on this change in wording which reversed the assumption against detaining the mentally ill, nor was there an Equality Impact Review undertaken. The current wording raises important issues over what mental illness can be treated in detention to a 'satisfactory' level, however defined, and the role of the Court in such clinical matters anyway. The judgment was that detention had been unlawful and breached article 3[95]. The Secretary of State abandoned her appeal, and subsequently it has been explained that an assessment of the public sector equality duty would be undertaken as part of the work commissioned by the Home Office from the Tavistock (see appendix 3). That study is also expected to assist in the reduction and elimination of situations of the Courts criticising the Home Office on the grounds of Article 3 violations. On the information currently available, the study may have great difficulty meeting its supposed aims.

Subsequent rulings are not straightforward, e.g. the cases of LE Jamaica[96] and Das[27]. Guidance is needed from the Court of Appeal on the lawfulness of the amended Enforcement Instructions and Guidance (EIG) in the context of other developments in immigration law[30]. There is relevant comment on this in the statement from the Royal College of Psychiatrists[103] (appendix 5).

In the last few years, there have been 3 additional cases where the Home Secretary has been found in breach of article 3 for 'inhuman or degrading treatment' in the context of indefinite detention of those with mental health needs[97,93,94]. This has led to further adverse comments[48,52]. In spite of the

significance of these cases, it seems as if the officials within UKBA did not get round to reading the judgments for some considerable time, which left them subject to criticism.

Discussion

The current situation is untenable for a variety of reasons. The impact of the current detention policy on individuals has been shown to be devastating. Some detainees or former detainees have had the resources to go to Court where judgments have been adverse for the Government (see table 2 in appendix 4) but many more have settled out of Court so those stories are largely hidden. Mental illness in detainees is unsettling for others and for staff, and risks stoking unrest[92,117]. There are also political risks from continuing a practice which is widely condemned by parliamentary committees, NGOs, the HMIP and others[52]. Mentally ill detainees have difficulty managing their interviews and immigration appeals, delaying decision-making in their case and increasing the risk of unsustainable decisions[67]. Late recognition of the merits of the detainee's case may mean refugee status is eventually granted, but only after an expensive and damaging period in detention.

A groundswell of opinion led to a commitment to end the detention of children, although the current practice in relation to child detainees remains problematic in that children continue to be detained. There has been a recent campaign against the detention of pregnant women. Those campaigns had support from Royal Colleges, and for this issue we hope for support from the Royal College of, Royal College of General Practitioners and Faculty of Public Health Psychiatrists[102,103]. There are many lobby groups that would support such a stand[67,72,110]. Only a handful of the many mentally ill currently detained are likely to have the 'very exceptional circumstances' that would justify continued detention. A case could be made for the Colleges to work on adapting clinical standards for the detention situation, adapted in part from those used in prisons or for refugees in the community[89,101]. However, doing so would in effect accept that detention of the mentally ill can be appropriate, when it is known to be damaging to these already vulnerable individuals, not mandated by any court process and there is a clinically preferable alternative. Professional advice may be appropriate, however, in the decision at what severity of mental distress non-detention should be mandated, based perhaps on symptom severity, diagnosis or therapy required.

Detention under the Immigration Acts of the mentally ill is unnecessary, costly and counter-productive. It goes against good professional practice and medical ethics. The transfer of healthcare responsibility for immigration detainees from the UKBA to the NHS provides an opportunity to look again and stop this practice. The medical professions should join others to ensure this happens.

A. Our aims for the future

As we discuss the current situation, it becomes apparent that the only barriers to change are political. There can be none working within the system who feel happy with the continued detention of vulnerable individuals with overt mental illness, even if they have grown to expect that 'this happens'. But it is largely avoidable. There is no evidence that the sorts of changes we would like to see would have an adverse impact on the bigger over-riding Home Office policy, to deal appropriately with the UK's borders and to control immigration. Indeed, we believe that if so much was not wasted unproductively on the mentally ill, resources could be freed up for alternative uses, either within the Home Office or Government more generally.

Schematic on the impact on mental health of immigration detainees from shifts in policy and practice

The first batch of our recommendations/aims are no more than the proper implementation of current Home Office policy, as also argued by others like HMIP and the IMBs. Detainees are expected to have health services to NHS standards and should do so. There should be no detention of those who are especially vulnerable because of torture, abuse or severe mental illness. Those who need ongoing treatment for medical conditions including mental illness are most unlikely to abscond. Requiring section under the Mental Health Act is unequivocal evidence of severe mental illness, and direct return to IRCs afterwards is neither necessary nor appropriate.

Elsewhere in Europe there is an upper time limit of 6 months for immigration detention and this should be more than long enough to deal with immigration issues and achieve removal, and if more time appears to be required then there are likely to be considerable barriers to the resolution of a case in the near future in any case. After 6 months, the process could continue with the now ex-detainee in the community on Temporary Admission with reporting requirements. Having an upper time limit for detention under Immigration Act powers would be a very positive step for the mental health of detainees.

In the table below on our overall aims, we list the action to no longer detain any mentally ill as intermediate or long term, but we are prepared to be pleasantly surprised by an early bold step by the present government. This is a high proportion of those currently detained, but continued detention serves to worsen the mental health of these already vulnerable individuals. It would be the right thing to do.

There is a more radical option, which would be to turn back the clock and seek wider use of community-based alternatives to detention[104]. This would deal with some of the failings of the former UKBA, now it seems being reproduced in the Immigration Enforcement Directorate. The financial savings would be very considerable: as found in the criminal justice system, bail is much cheaper than custodial care[66]. The political narrative could be that freed up resources could be used more sensibly in dealing with the extensive backlog of claims and the irregular migrants in the community. It might seem far removed from the policy of the current government, but if a brave decision was taken to reduce costs with minimal impact on removals/deportations, this step needs serious consideration.

Table 3

MHIDAG overall AIMS	Rationale	When ?
Incarceration of the mentally ill immigration detainee is unnecessary, unethical, damaging to the individual and counterproductive.	Overall rationale	
Stopping detention of those ill enough to need treatment for mental illness	Since detention makes it worse and treatment in IRCs is substandard	Intermediate term ie after 2015
Limiting any detention period to 6 months	Since mental health deteriorates with indeterminate and with longer detention	Intermediate term ie after 2015
Stopping detention of those ill enough to be/have been under MH section	Since this is unequivocally severe mental illness	Short term
Stopping detention of those who are especially vulnerable because of severe mental illness, torture, or other abuse	Because of the especially adverse impact of detention	Short term
Ensuring the diagnosis and treatment of mental conditions meets the standards expected in the NHS, including access to the full range of non-primary care services	Since this is what a civilised society expects for those unable to access healthcare for themselves	Short term

As well as the broad aims from this group as given above, we have more detailed comments for specific audiences, as given in table 4 below, with comments.

Table 4 (in no priority order)

whom	argument	comment
Home Office	Should opt in to article 15 of Returns Directive (2008/115/EC)	But should be possible to limit duration of detention without this, just by Home Office/IE instruction
Immigration Enforcement (IE) and IRCs	All IRC and IE staff to have mental health awareness and MH first aid training	Existing policy but implementation frequently not achieved
IE and IRCs	All IRCs to have policies for identifying and dealing with challenging behaviour related to mental illness, using the same least restrictive and participation principles that govern the application of the Mental Health Act 1983	
IE and IRCs	Segregation of detainees, as in prisons and as recommended by HMIP, should be conditional on a medical assessment of mental health, and involve regular multidisciplinary reviews, and never be used as a substitute for proper treatment of mental illness	Detailed policy guidance needed with audit
Home Office, IRCs, NHSE	There should be safeguards such as regular audit and multidisciplinary reviews on the use of force on mentally ill detainees	
Home Office NHS England	NHS-equivalent mental health healthcare standards, agreed, resourced and audited	New standards to be expected with NHS commissioning

and IRC healthcare		
NHS England and IE	Full range of mental health services available, including counseling by those skilled in PTSD	Currently many services are only available to those in the community
Home Office NHS E and IRCs	Independent professional interpreters must be available for interactions with IRC healthcare	Especially important for some mental health and abuse-related issues
IE and IRC contractors	Proper assessments under rule 34 including access to previous clinical records	Frequent failing to meet Home Office policy
IE and IRC contractors	Proper reports under rule 35, with proper respect for professional opinions	Frequent failing to meet Home Office policy
BMA, SEG, Royal Colleges, GMC, IRC doctors	There is a professional responsibility to generate rule 35 reports when appropriate, and not to be satisfied if they are rejected	Need to have professional guidelines, with audit and link-in to the appraisal process
Home Office and IE	Detention of people with serious mental illness should not happen, even if it is argued that it can be managed satisfactorily in detention.	But if it does happen, then it needs the same safeguards as apply to mental health section, e.g. approval of 2 mental health professionals or of an independent panel of experts
Home Office and IE	The mentally ill should never be held in the detained fast track	Facilities and safeguards are grossly inadequate
IRC healthcare staff including psychiatrists, NHSE, Home Office	Detainees who become so unwell they need to be treated in hospital should be subject to clear protocols to ensure they are transferred out of detention within timescales that comply with the law and are treated with the 'least restriction' principle under the Mental Health Act (usually as a voluntary or community patient)	Expected professional practice
IE	Detainees who have been ill enough to be sectioned under the MH Act should not be returned to detention	This limited group has the most severe mental illness, and would be expected to deteriorate when back in detention
Home Office	People should not be detained when to do so is likely to mean that they lack capacity to participate in their immigration case	Defeats the stated rationale for detention
Home Office and IE	Equality impact assessment of the new wording of the EIG, following undertaking in *HA (Nigeria) v SSHD*	now said to be taking place under a commission with the Tavistock, but there is no confidence this is indeed the case or will be satisfactory
Home Office and NOMS	Immigration detainees in prison to be able to access rule 35 equivalent	Prison rules version provides a lesser safeguard
Home Office and IE	Detainees in STHFs to be able to access rule 35 equivalent	
NHS E, IE, IRC healthcare contractors	There should be no practical barriers for all detainees with possible mental illness being able to access an independent medical report	But the capacity to do this is limited
NOMS, NHS E	Immigration detainees held in prisons should not be disadvantaged, compared to those in IRCs or to other prisoners. Their good mental health may well depend on ease of access by	If the prison population of immigration detainees continues to increase, the

	phone or in person to family and lawyers, as well as culturally appropriate diagnosis and treatment, including for potential PTSD	needs and rights of this group may need more attention
Home Office, Treasury, NAO, PAC	Incarceration of the mentally ill detainee is expensive and delays decision-making. Releasing the mentally ill from IRCs could help solve the accommodation crisis in prisons without expensive new builds, by freeing up places for transfers from prisons	Not able to quantify at present
NHSE, Home Office, IRC contractors, LAs hosting IRCs	Accessible information about mental health to be available to those detained, in appropriate formats and languages, to include information about mental health services, MH advocacy and the Samaritans	
Policy makers, political think tanks, ministers, parliamentarians	Detention is not a pre-requisite to the fair implementation of immigration policy. Most awaiting decisions on their immigration status already do so in the community	Absconding statistics from the community would enable a proper cost-benefit analysis of the increasing detainee population
Policy makers, political think tanks, ministers, parliamentarians	The cost-benefit from the detention of the mentally ill is even more unfavourable than for well detainees, and becomes counter-productive to the determination of their immigration status	Deterioration in detention, means handling of immigration cases becomes increasingly problematic, and capacity may be lost for this, as well as generating unfitness to fly.
Policy makers, political think tanks, ministers, parliamentarians, press, health professionals, professional bodies	The current treatment of mentally ill detainees is a disgrace and indefensible. The Court cases are just the tip of the iceberg. There is a growing consensus against detaining the mentally ill. The alternative of handling in the community can be made politically acceptable. Because of their special vulnerability, the detention of the mentally ill needs to be seen as unacceptable as the detention of children	
NHSE, CCGs, NHS trusts, community services inc LAs	There should be protocols to ensure there is proper liaison between healthcare services in detention centres and outside healthcare services, in particular for when detainees are released	
Health professions	Immigrants who are mentally ill are detained for administrative convenience and that cannot justify their current poor diagnosis and treatment, in circumstances under which mental health is known to deteriorate	Support by evidence-based articles for the medical press
Press as a route to influence public opinion and hence policy makers	The current arrangement is inefficient and clogs the system up with troubled and damaged detainees who increasingly are in no fit state for removal anyway. Good community-based treatment for mental illness may speed up decision-making on status, and for those given leave to remain, reduce the time before they can contribute positively to UK society.	
Press, as a route to influence public opinion and hence policy	Publicity on a dossier of evidence and arguments, backed up by multiple cases	Initial report from this group has potential to do that, but may not be taken up by the press that influences current policy makers

makers		
NHS England	A health needs assessment (HNA) is required to quantify the current problem of mental ill-health in immigration detention. More appropriate policies for treatment could then follow	Collation and supplementation of existing HNAs needed, leading to a revised service specification for IRC mental health care
The Courts	Good arguments on individual cases about inadequate and degrading treatment, breaches of HRA, rule 35 etc, helping set case law in the most helpful direction. Challenge to the assumptions about the only treatment of severe mental illness being in hospital, as in the case Das, R v SSHD	This report could be helpful background
IMBs, HMIP, Healthwatch, Health and well-being Boards, etc	We need to work together to improve matters for mentally ill detainees, at the least ensuring the following of those aspects of current official policy that safeguards detainee health	
First-tier Tribunal (IAC) judges hearing bail applications	It is for the Home Office to justify the need for continued detention each month and at a bail hearing. The statutory restriction on the grant of bail on mental health grounds should only be relied on where there is adequate evidence before the Tribunal. Outdated views as to the appropriate places for treating mental illness need correcting	Offer to help educate about detainees and about the right place to treat mental illness
Parliament	Repeal 30(2) second schedule to the Immigration Act 1971, say by using the latest Immigration Bill to do this.	Inaccurate reasoning about the best place for mental health treatment

Potential next steps for this group

This group came together under the auspices of MIND and Medical Justice, supported by others with a close interest in the mental health of immigration detainees. We were impressed by the briefing paper done by AVID and BID[67] but concerned that like them we would be unable to do not much more than document the sorry state of affairs. Hence we called ourselves an 'Action Group' giving ourselves 6 months to review and reconsider what we had achieved. This is the report from those first 6 months.

There has been much synergistic learning from the experts around the table and from others with whom we have corresponded. We remain concerned that the current situation is untenable, most especially for very many immigration detainees who are especially vulnerable because of mental illness. There have been opportunities for the group to respond to consultations or enter in correspondence with officialdom (not all of which is documented in this report), but the overall climate for the mentally ill detainee feels to have deteriorated nevertheless. Some Court judgments have been very positive, others not so, but these seem to have led to entrenchment of government policy rather than the opposite.

The current plan is to promulgate this report and ensure those fingered in our table 4 are aware of our thinking and its rationale. The report will be used to help influence policy-makers and others like the media to whom they listen. Everything we have done to date has been unfunded, and it is uncertain how long we can continue in this way. Since the need continues, with continued avoidable harm being done to this most vulnerable group, it looks like a grouping such as ours needs to continue too.

Conclusions

The UK continues to detain mentally-ill immigrants unwanted by the authorities. This practice is known to worsen mental health yet further. The detention of the severely mentally ill has little support from official inspectorates, detention centre visitors and monitoring boards, nor from many

parliamentarians and judges. The Immigration Enforcement's own rules are ambiguous in this regard. The transfer of overall healthcare responsibility from the Home Office to the NHS provides an added impetus to address this issue. Arguments are presented why change is necessary and appropriate in this shameful status quo, expecting thereby to be able to save costs, improve lives and better mental health.

Appendix 1

The Mental Health in Immigration Detention Action Group

Name	Organisation	Role
Dr Hilary Pickles (chair)	Medical Justice / independent	Public health
Prof Cornelius Katona	Helen Bamber Foundation / RCPsy Asylum WG	Consultant psychiatrist
Dr Sarah Majid	RCPsych asylum WG	Consultant Psychiatrist
Sue Willman	Deighton, Pierce Glynn Solicitors	Solicitor (partner)
Martha Spurrier	Doughty Street Chamber	Barrister
Alison Fiddy	MIND	Solicitor, Head of legal
Jed Pennington	Bhatt Murphy Solicitors	Solicitor
Camilla Graham Wood	Birnberg Peirce & Partners	Solicitor
Hamish Arnott	Bhatt Murphy Solicitors	Solicitor (partner)
Khuluza Mlotshwa	Zimbabwe Association	Law student
Aisha Kabjja	Medical Justice trustee	Student
Emma Mlotshwa	Medical Justice	Co-ordinator
Theresa Schleicher	Medical Justice	Casework Manager
Adeline Trude	BID	Research and policy manager

Terms of Reference

1. The Mental Health and Immigration Detention Action Group (MHIDAG) is a voluntary and unfunded group with a membership of lawyers, health professionals, ex-detainees and NGO workers.
2. The MHIDAG:
    a. is seriously concerned about the mental health of those held under Immigration Powers,
    b. considers that aspects of the current detention and healthcare policy and their current implementation are detrimental to the mental health of immigration detainees,
    c. and will be marshalling evidence and submissions to influence a change for the better for both individual detainees and detainees as a whole
3. The MHIDAG will do its work through collaborative discussion and information exchange and through influencing external bodies.

Appendix 2

Recent and Ongoing Research on immigration detention in the UK relevant to mental illness

Mary Bosworth (Oxford University)
Development of the MQLD – Measure of Quality of Life in Detention, an adaptation of the Measure of Quality of Prison Life (MQPL). This was designed tested and piloted in Campsfield House and Colnbrook in 2009-10, and further refined in Yarl's Wood, Brook House and Tinsley House 2010-11. Questionnaire includes a measure of depression in an abbreviated form of the Hopkins Symptom Check-list (HSCL-D). Initial results reported in 2013[11]. Research project/studentship funded by ESRC and HIMP for 3 years for further development of the MQLD.

Dr Piyal Sen with Masters students at Dover IRC
Permission has been granted for a study, now awaiting final ethical approval.

Katy Robjant
No current research in this area, but undertook in 2008/9 what she believed was then the only formal study, and reviewed the then literature[99,100]. Would be interested in being engaged in further work

Elizabeth Connely for the Detention Forum (Vulnerable peoples working group)
Questionnaire study on those who could or should be considered vulnerable in detention to explore how the UKBA/HO is screening for this and how highlighted vulnerabilities are 'managed'.

Ms Sukhmeet Singh and Dr Catherine Harkin
Outline proposals by this medical student in Edinburgh who has just done an intercalated degree in psychological medicine to study ex-detainees, compared with never detained people, looking at factors that may have helped or hindered their mental health.

Independent Advisory Panel on Deaths in Custody
The University of Greenwich and the Runnymeade Trust have won a tender exercise to deliver a programme of research and analysis in 2013/14 and 2014/15. Deliverables to include a systematic review of the role of mental illness and deaths in all state custody. The majority interest is in prisons, but all state custody including IRCs are expected to be covered[e].

Medical Justice data base
Were funding made available to support a research worker, then a study could be mounted of the sort that was undertaken on detainees and ex-detainees who were torture survivors or those that were pregnant[69,110]. Those still in touch with MJ could be approached for their permission to use the clinical notes held by MJ and/or to participate with further questionnaire/interviews, relating to mental health issues. Although a self-selecting and biased group, confounding factors could be described and accounted for in the analysis.

Dr David Lawlor (Tavistock institute)
See appendix 3

Other UK commentators have been reporting individual cases, unrepresentative series, ad hoc or routine audits, hospital activity data, or reviewing secondary data or the general sorry state of affairs (see 3rd set in the tables of quotes in appendix 4).

[e] Press release. News. IAP research and Analysis on http://iapdeathsincustody.independent.gov.uk/news/iap-research-analysis July 2013

Appendix 3

Review by Dr David Lawlor (Tavistock Institute) on the Mental Health Issues in Immigration Removal Centres

This study was commissioned from the Tavistock Institute by the Home Office in early 2013. The information below was that shared with those invited to a workshop in October 2013

UKBA required a review of existing procedures and guidelines to ensure an adequate provision for the mental well being of detainees in the context of its responsibility to remove immigration offenders from the UK. An important objective was to reduce and eliminate situations of the Courts criticising the Home Office on the grounds of Article 3 violations. The other objectives of the Review were to: consider what can be done to improve:

- *The identification and treatment of mental health conditions in removal centers*
- *The way in which mental health conditions are taken into account in caseworkers' decision making*
- *Communication between removal centers, caseworkers and NHS Trusts*

It was agreed to conduct visits to a number of detention centers (Colnbrook, Harmondsworth and Yarl's Wood IRCs) and caseworkers based in Croydon. Also to gather information from external stakeholders.

The target group for the review and any follow up intervention was staff in two categories, ie the case workers who generally work remotely with no contact time with detainees, who are Home Office staff; and IRC contractors that apply the mental health policies and provide healthcare services. The Review design was grounded in visits of the above centers and exploration of the experience of working with mental health problems. This was achieved by interviews, focus groups and feedback to center staff on our observations and hypotheses. We spent a day in each centre. The day had a series of meeting with key staff and inmates (sic). We met with staff in the Detention Centres, and explored their experience of mental health problems within the Centres. This work was complemented and triangulated by focus groups with case workers not based in the IRCs. The collected data were analysed using thematic data analysis approach

The Review was conducted by the Tavistock Institute with cooperation from relevant Home Office directorates and was overseen by a Steering Group. The Steering Group functions are to: Oversee and provide directional guidance to the project; Agree the terms of the review; Agree timescales for the report; Bridge the gap between the project and the wider Home Office, providing information on related projects; Monitor the progress of the review; Raise matters of concern

MHIDAG concerns about this work include:

- The failure to include non-Home Office stakeholders in the steering committee. For example, even though they will shortly be responsible for mental heath care in detainees, DH and NHS England were not involved
- The limited range of external stakeholders engaged, and this being very late in the process when the major conclusions had already been formulated
- The inadequate and biased information used by the Tavistock team. The reading list they shared with the workshop participants did not include any legal case reports, peer-reviewed literature, reports from NGOs and very few inspectorate reports
- The inadequate time being taken to become familiar with a highly complex topic
- Many other aspects of their methodology, such as the representativeness of those they spoke to
- No element of the expected methodology for equality impact assessments, although we had been told this study would be satisfying the formal commitment to undertake such an assessment made in relation to the case of HA[95]
- We do not know how much the output would be made public, but it is assumed that the report will be accessible using FOI

Appendix 4

Verbatim but highly selective quotes about mental illness in immigration detainees

Note : Please always check the original before quoting so this can be done in context

Table A - Highly selective Quotes from official reports

Quote	Who by	ref
...67% of detainees said they had health problems, with 53% describing mental health problems, such as depression, stress and anxiety. Those held for more than six months were much more likely to describe such symptoms…..The Rule 35 process did not provide the necessary safeguards for vulnerable detainees	HM Inspector of Prisons & Independent Chief Inspector of Borders and Immigration	48
'We are concerned about a number of issues …in regards to immigration detention – in particular the treatment of detainees suffering from mental illness at Harmondsworth Removal Centre…' 'If medical practitioners have advised that detainees should be accommodated in hospital or other institutions that care for the mentally ill then that guidance should be acted upon by the Agency and not ignored' … 'We are concerned that the cases outlined above may not be isolated incidents but may reflect more systemic failures in relation to the treatment of mentally ill immigration detainees'	Home Affairs select committee Nov 12	52
I do not think there is a direct link between incidents of suicide, self-harm and mental health risk and disturbances in IRCs. But insofar as they contribute to anxiety and frustration, especially among FNPs, they are a closely relevant factor. And they must continue as a focus for attention, whether or not they contribute to unrest, because of the duty of care to the individual detainee	R Whalley 2007	117
My visits to removal centres revealed that a significant proportion of detainees suffer from mental health problems, and that these increase significantly over time in detention. Ex-detainees to whom we spoke also referred to the presence on the wings of people who were clearly mentally ill. Self-harm is worryingly common. Given the background of many of these people, and the emotional and financial investment they have made to get to this country, it is not to be wondered at if they suffer more than usually from stress and depression or if their continued detention and uncertain future exacerbate this	Stephen Shaw, Prisons and Probation Ombudsman	92
Overall this is a deeply depressing report…. ..there was no regular input from community mental health teams and a lack of active nursing input for detainees with severe…mental health needs ….. We found a lack of nursing input into the care of one detainee who had become agitated and distressed. Although she was subsequently seen and treated by a psychiatrist, a nurse who had been on duty since 7am told us at 2:15pm that he had not yet seen the detainee that day. There was also no documented care plan for this detainee, which was unacceptable practice.	HMIP Tinsley House 2009	41
A major area for ongoing concern was healthcare, which remained a source of considerable complaint from detainees. Mental health needs were underidentified and the inpatients department was described by staff themselves as a 'forgotten world' …Only in exceptional circumstances should mentally ill people be detained and their needs should be fully assessed and met during any such detention. Medical evidence that a detainee's mental health is being adversely affected by continued detention	HMIP Harmondsworth 2011	46

should trigger a prompt review of detention by the UKBA caseworker		
In relation to a previous recommendation for health services staff – 'None of the staff had received formal training in the recognition or understanding of the consequences of torture'…'There was no dedicated space for mental health nurse clinics and nurses told us that it was often difficult to find a suitable private place to see patients' …'Assessments under the Mental Health Act should be expedited to ensure that detainees with acute or significant mental health needs are cared for in an appropriate setting'	HMIP Colnbrook 2010	43
Health care outcomes were reasonable overall, but there were significant shortcomings in mental health provision… There was poor integration between primary and secondary mental health care. This reflected substantial risks that needed urgent attention….Referrals and assessments in relation to whether detainee's mental or physical health could be adversely affected by detention should be consistent and multidisciplinary	HMIP Tinsley House 2012	49
The IMB was 'constantly surprised and seriously concerned by cases where a decision by a doctor that a person is unfit for detention is overruled by case owners'	IMB Harmondsworth 2011	58
Some are detained for years and boards are concerned at the impact of such long-term, indefinite detention on their mental health.	UK's National Preventive Mechanism 2011	76
IMBs are particularly concerned about the deterioration in the mental health of detainees in long-term, indefinite detention	UK's National Preventive Mechanism 2012	77
Although detainees had good overall access to healthcare services, there was a paucity of mental health support…… There was no programme of mental health awareness training for either custody staff or health care professionals	HMIP Brook House 2012	42
Rule 35 reports….were poorly understood by health staff and badly completed. …….There should be robust primary mental health services for detainees and regularly held mental health clinics. All staff should receive mental health awareness training	HMIP Yarls Wood 2011	45
..the process intended to provide safeguards to detainees who were not fit to be detained, or had experience of torture, did not appear to be effective	HMIP annual report 2010-11	44
..there were significant concerns about provision for detainees with mental health problems at some centres…There was also no mental health awareness training for custody staff	HMIP annual report 2011-12	47
All but three interviewees (86%) said the experience of open-ended detention had left them feeling depressed and considering self-harm or suicide, and this issue pervaded both the Inspectorate interviews and IMB surveys. Some made a clear distinction between the impact of prison sentences and that of immigration detention	HMIP Foreign national prisoners: a follow up report 2007	40
…an inadequate level of support for detainees with mental health problems. ….no access to conselling services for detainees….Detainees with enduring mental health problems were not sent to the centre and none were managed using the care programme approach…..There was no programme of mental health awareness training for either custody staff or health care professionals	HMIP Brook House 2010	42
Again this year we highlight the total lack of appropriate accommodation, and therapeutic day care…for those who are mentally ill….We are continued to be shocked by the detention of those who are mentally ill…..Detainees who are unfit for detention should, according to Rule 35…be released. In 2012 125 detainees were found by GPs employed at the Centre to be unfit to be detained but only 12 were released.	IMB Harmondsworth annual report 2012	59
Patients should have access to a full range of timely support for mental health problems, including counseling, clinical psychology and group therapies	HMIP Morton Hall 2013	50
Provision (of primary and secondary mental health services) was generally insufficient to meet need. Responses from caseworkers (on rule 35 reports on mental illness) were	HMIP annual report 2012-13	51

often dismissive and none of those we reviewed led to release		
The CPT is concerned by the rise in the number of persons being detained for lengthy periods in IRCs; in certain cases, it would appear that there was little prospect of the persons concerned being sent back to their countries of origin. Continuing to hold a person in immigration detention in such circumstances would appear to be a disproportionate measure, and the indefinite measure of detention could lead to a deterioration in mental health	European Committee for the Prevention of Torture and inhuman and degrading treatment or punishment	24
….mental health service provision was insufficient to meet the high levels of need…… ..at Colnbrook IRC no formal mental health provision existed and at Harmondsworth IRC, although there was formal mental health provision little psychosocial intervention was available. Similarly, at Yarl's Wood IRC although there were mental health nurses and counseling, both staff and detainees felt current provision was insufficient to meet needs…… .a need for more training on working with ..detainees with mental health problems…. Yarl's Wood: mental health problems were perceived by the healthcare manager and detainees to be an area of high and growing need Harmondsworth: self-reports suggested high levels of both mild and moderate to severe MH problems with limited access to psychosocial interventions Colnbrook: High levels of mild and moderate mental health problems with limited access to interventions	G Lewis and R Meek, Royal Holloway, University of London	119

Table B - Quotes by or about individual detainees

Quote	Who by?	About?	ref
I find that S was subjected to inhuman or degrading treatment in both the fact of his detention which was contrary to the undisputed expert psychiatric and medical advice and the continuation of his detention as his mental condition deteriorated rapidly……Even the recommencement of serious self-harming by S did not stir the UKBA to effective and urgent action	David Elvin QC	S	97
By the time of his compulsory return to an IRC it was known that the Claimant had a severe mental illness which had not been treated for many months when he was previously in IRC detention. …The Claimant was unlawfully detained….The length of time that it took to secure the Claimant's transfer to hospital …was manifestly unreasonable and unlawful	Mr Justice Singh	HA (Nigeria)	95
…BA had been detained in Harmondsworth IRC for 156 days. By this stage, it was and had been clear for some time that detention was having a serious effect on BA's mental and physical health……A crescendo of professional voices expressed the view in the course of July [2011] that he was unfit to be detained….There is now clear evidence of the effect of prolonged immigration detention on the physical and mental health….In my judgement there was a deplorable failure, from the onset, by those responsible for BA's detention to recognise the nature and extent of BA's illness…he was not seen by a psychiatrist until May 2011. At the time of the proposed interview, someone had forgotten to give him his medication for a week…..his eventual transfer to hospital was significantly delayed	Elisabeth Laing QC	BA	93
On admission…the Claimant explained he had previously been	Charles George	D (Congo-	94

treated for mental health issues and had been 'sectioned'.....I find that throughout the five and a half months that the Claimant was in Brook House he was never given any anti-psychotic drugs. He also never saw a psychiatrist…… records ..refer to D's earlier diagnosis with paranoid schizophrenia in 2008 and to his history of threats of violence towards UKBA and escort staff, but do not draw any connection between the two… …….throughout his period in Harmondsworth the Claimant never saw any psychiatrist… The Claimant says that he went to the healthcare unit and told them that he was hearing voices and wanted medication. He asked to be transferred to a different detention centre which had a psychiatrist and was told that was not possible. He was then put in segregation for two days Dr Tracy (independent psychiatrist) recorded 'marked derangement in his thinking – a symptom of the severe form of the illness [paranoid schizophrenia].	QC	Brazzaville)	
Both a psychologist and a psychiatrist concluded 'that D had the mental age of an 11 year old. Despite this, D was held in isolation in Brook House for 6 weeks.' 'He has evidently been emotionally scarred from being detained in isolation for so long'	Visitor	D	67
M..suffers from chronic disorganised schizophrenia. ..he was sectioned under the MHA on two occasions….After 6 months in immigration detention, he was admitted to hospital under MH section again. On return to an IRC, an independent psychiatrist noted that M's health had deteriorated as a consequence of detention, and noted real concern for M's health should he remain in detention. He was being prescribed with the wrong medication and was not getting the appropriate therapeutic support. The IRC doctor had subsequently stopped the depot antipsychotic injection….		M (east Africa)	67
Torture victim, after 2 months in detention the independent doctor diagnosed psychotic illness with auditory hallucinations and paranoid thoughts. He wrote 'given his current condition I believe that it is detrimental to detain him at the IRC...He requires psychiatric evaluation and treatment as a matter of urgency'….3 months later Hemingway 'was granted High Court bail on the condition that he be transferred immediately by the authorities to hospital for an urgent psychiatric assessment and treatment. The authorities were ordered to meet the costs of the private medical care'		Hemingway	110
IRC GP recorded 'history of PTSD with psychosis, reports intense voices at night…voices of police men telling him to kill himself, images of police and flashbacks of being tortured and raped which took place after his arrest' Consultant psychiatrist writes 'My impression is of severe PTSD which has worsened in detention..' Removal Directions were set by UKBA, but Casper was not fit to fly, was released and received refugee status		Casper (Sri Lanka)	110
Prior to arriving in the UK, diagnosed with schizophrenia. Spent over 3 months in detention. During this time, his health deteriorated significantly. Despite being a victim of torture with a severe and enduring mental illness, he did not have a rule 35 report completed.		George	110
This involves the detention of somebody with mental illness	Sir Michael	T (Zimbabwe)	98

consisting of PTSD and severe depression…Dr Katona's report..' stated that the claimant's continued and open-ended detention had increased the risk of suicide and was aggravating his PTSD symptoms. If ever there was a report which should have galvanised the defendant into considering the appropriateness of the claimant's continued detention, that was it. Yet again, there was a complete failure by the defendant to address that issue'	Harrison		
He described a number of mental health problems including low mood, insomnia, loss of appetite, anxiety, nightmares and flashbacks…His demeanour while describing the sexual abuse along with the physical sequelae such as peri-anal pain, rectal bleeding was of extreme reticence and distress as would be expected of a victim of sexual violence….Harmondsworth noted in his screening that he had no history of mental health and no history of torture. This is clearly incorrect….Ali had never been referred to a psychiatrist despite trying four different antidepressants at varying doses		Ali	110

Table C - Key findings/quotes from peer-reviewed papers (UK unless indicated)

Quote	Author	About	Ref.
'The level of distress among the survey population was very high with four-fifths of the respondents, 82.9% (n=131), classified in the abbreviated form of the HSCL-D with depression…Those who were more depressed were more likely to have been in detention longer, to have applied for asylum, to have refused food in protest, to be out of contact with their family and to report health problems'….'a common theme emerged, from staff as well as detainees, concerning the open-ended nature of the detention and the bureaucratic nature of the immigration decision-making process'	M Bosworth and B Kellezi	Random sample of IRC residents 2009-2011	11
'Detained asylum seekers had higher scores than asylum seekers within the community for depression, anxiety, and PTSD symptoms. ..Immigration detainees are highly vulnerable to psychological distress'	K Robjant, I Robbins, V Senior	67 detained asylum seekers	100
'We found that detainees are rendered hopeless and powerless in detention…The unpredictable outcome of detention, in particular fear of deportation is a constant cause of stress…The responses to detention, including despondency, demotivation, anxiety and depression are understandable responses to an abnormal situation. They can manifest in constellations of symptoms consistent with diagnoses of post-traumatic stress disorder, depression, anxiety and psychosis… These are not always identified by medial staff'	C Pourgourides	Qualitative study on asylum seekers in detention	88
'The scanty data [that] were available from Immigration Removal Centres, coroner's records and Prison Ombudsman reports showed high levels of self-harm and suicide for detained asylum seekers as compared with the UK prison population'	J Cohen	Asylum seekers in the UK, in detention and community	21
Ten studies were identified. All reported high levels of mental health problems in detainees. Anxiety, depression and post-traumatic stress disorder were commonly reported, as were self-harm and suicidal ideation. Time in detention was positively associated with severity of distress. There is evidence for an initial	K Robjant, R Hassan, C Katona	Studies in UK, Australia and US	99

improvement in mental health subsequent to release, although longitudinal results have shown that the negative impact of detention persists			
'The results showed that 66 per cent of the participants entered detention with pre-existing mental or physical conditions that required ongoing or new treatments. In addition, new mental/emotional (93%) or physical (53%) health problems arose for the majority of the participants within detention	S Zimmerman, D Chatty, M Nørredam	30 former detainees	118
'At least 33 of our patients fulfilled ICD10 criteria for Post-Traumatic Stress Disorder or depression. Many had either harmed themselves or made determined attempts at suicide. Official guidance that people with serious health problems including mental illness should not normally be detained, was not followed in these patients.'	Arnold F, Beeks M, Fluxman J, Katona C, deZuletta F.	56 failed asylum seekers case series	3
We found a high level of psychological disturbance in all cases. Symptoms included intense fear, anxiety, sleep disturbance, nightmares, irritability and frustration. Six spoke of feeling that they were 'going crazy'. All reported depressed mood, appetite loss, and multiple somatic complaints. Nine said that they had frequent episodes of tearfulness and felt completely hopeless	P Bracken and C Gorst-Unsworth	10 male asylum seekers seen in detention	12
Mental health problems were the overriding health issue in this report with 41% of interviewees experiencing one or more mental illnesses. Depression, stress and anxiety were the most common mental health problems reported by all interviewees. Five out of seven interviewees with diagnosed mental health conditions stated that they have not been seen by a mental health professional or received counselling during detention…. For almost everyone interviewed 'indefinite detention' created an atmosphere of uncertainty, anxiety and fear of the unknown	Inegbenebor D, Sagba F K et al	Interviews/focus groups with 21 Africans in or from IRCs in the UK (not peer reviewed)	60
A high proportion of detainees exhibit mental distress or frank mental illness, exacerbated by the uncertainty of their indeterminate sentence. Mentally ill detainees are often at high risk, including from suicide……..patients such as torture survivors or those with florid psychosis often continue to be detained despite doctors' opinions that detention is harming their health……The most obvious solution for people who are mentally ill is to find alternatives to detention	Pickles H and Hartree N	Editorial	86
As I renew my appeal to policy makers to finally end child detention…I would also like to extend that appeal to those with serious mental illness. The research outcomes are plain to see. We cannot, as professionals in a humane society, continue to allow this widespread detention of the most vulnerable in society, be they children, teenagers or mentally ill	S Dosani	e-letter (not peer reviewed)	28
The absence of any baseline data on mental health within the detained population is problematic, particularly for those with severe and enduring mental health needs and for whom detention can have an extremely detrimental impact….It is important to remember that immigration detention is administrative rather than punitive, and that detainees are not prisoners – as such, the fullest range of treatment options should be considered and this must include alternatives to detention such as community release	A McGinley	e-letter (not peer reviewed)	68
It is hoped that the Home Secretary will stand by her undertaking…and addresses the serious adverse impact that her policy is having on mentally ill detainees…..Mind also believes that	M Spurrier	e-letter (not peer reviewed)	106

people who are susceptible to periods of crisis mental health breakdown, are never fit for detention			
Doctors working in voluntary agencies regularly come across cases of poor care for recently detained immigrants. These include gross examples of physical and mental illness, including blatant evidence of torture, that have been untreated or ignored in detention	J Launer	e-letter (not peer reviewed)	63
Asylum seekers who have been tortured in their home country are so terrified of return that they seriously self harm – cutting themselves, attempting suicide, refusing food. They have limited access to psychiatric help despite such profound despair.	C Goldwyn	Letter, based on experience of visits to 306 in IRCs	35

Appendix 5

RC Psychiatrists: position statement on detention of people with mental disorders in Immigration Removal Centres

The position statement is available on the Royal College of Psychiatrists website ;
http://www.rcpsych.ac.uk/pdf/Satisfactory%20Treatment%20in%20Detention%20document%20FINAL.pdf

Appendix 6

Submission to Transforming legal aid consultation

The submission is available on the Medical Justice website ;
http://www.medicaljustice.org.uk/reports-a-intelligence/other-organisations-reports/ngos/2248-mental-health-and-immigration-detention-action-group-response-to-transforming-legal-aid-consultation-june-2013.html

Appendix 7

Submissions to Joint Committee on Human Rights

Submission by the Mental Health in Immigration Detention Action Group to the Joint Committee on Human Rights call for evidence on human rights judgments (2013) - available on the Medical Justice website ;
http://www.medicaljustice.org.uk/reports-a-intelligence/other-organisations-reports/ngos/2249-submission-by-the-mental-health-in-immigration-detention-action-group-to-the-joint-committee-on-human-rights-call-for-evidence-on-human-rights-judgements-2013.hh

Appendix 8

Submission to consultations on access of migrants to health

Collective response from the Mental Health In Immigration Detention Action Group to "Sustaining services, ensuring fairness : A consultation on migrant access and their financial contribution to NHS provision in England" - available on the Medical Justice website ;
http://www.medicaljustice.org.uk/reports-a-intelligence/other-organisations-reports/ngos/2250-mhidag-response-to-sustaining-services-ensuring-fairness-a-consultation-on-migrant-access-and-their-financial-contribution-to-nhs-provision-in-england-2013.html

Appendix 9

MHIDAG letter about misleading Lords reply on rule 35(1)

6 August 2013

Dear Lord Roberts

I write on behalf of the Mental Health in Immigration Detention Action Group, which is a multi-disciplinary group established to improve Home Office decision making in the context of the immigration detention of the mentally ill and to improve the way in which this group are treated in immigration detention. Further information about the group, including details of its members, is appended.

We write regarding an answer given by The Parliamentary Under-Secretary of State, Home Office (Lord Taylor of Holbeach) to a question you asked about the numbers of asylum seekers deemed by healthcare professionals to be unfit for detention in each of the last ten years, and of that number, how many were subsequently released as a result.

In summary, in our view the Minister did not satisfactorily answer your question because (i) reports under Rule 35(1) of the Detention Centre Rules SI 2001/238 (DCR) are not the same as assessments by IRC medical practitioners that detainees are unfit for detention and (ii) in our experience medical practitioners often report such assessments to the Home Office outside of the Rule 35(1) DCR process. A further issue is that the answer does not distinguish between releases that happen as a result of Home Office decisions and those ordered by courts and tribunals. The consequence of the unsatisfactory answer to your question is that Parliament is not aware of the numbers of detainees who have been assessed as unfit for detention who the Home Office has continued to detain. In our experience, it is likely that such detainees have been and are being unlawfully detained, either due to their detention being contrary to Home Office policy or their rights under the European Convention on Human Rights.
For ease of reference, we set out your question and the Minister's answer:

Asked by **Lord Roberts of Llandudno**

> *To ask Her Majesty's Government how many asylum seekers were deemed by healthcare professionals to be unfit for detention in each of the last ten years, and of that number, how many were subsequently released as a result of such findings.[HL1011]*
>
> ***The Parliamentary Under-Secretary of State, Home Office (Lord Taylor of Holbeach):*** *This question has been interpreted as relating to Rule 35 (1) of the Detention Centre Rules 2001, which sets out requirements for doctors at immigration removal centres to report on any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.*
>
> *Management information for the administration of reports submitted under Rule 35 (1) is only available from one January 2012. This information does not form part of published statistics and is not subject to the detailed checks that apply to National Statistics publications. As such, it is provisional and subject to change.*
>
> *Records prior to this period were locally held manual records for administrative purposes and are not available without incurring disproportionate cost.*

	Q1 2012	***Q2 2012***	***Q3 2012***	***Q4 2012***	***Grand Total***
Number of Rule 35 (1) reports	*34*	*31*	*9*	*24*	*98*

	Q1 2012	*Q2 2012*	*Q3 2012*	*Q4 2012*	*Grand Total*
Number of detainees Rule 35(1) reports relate to	*31*	*29*	*7*	*22*	*89*
of which:-					
Detainees released following Rule 35(1) report	*1*	*2*	*-*	*1*	*4*

Decisions to release individuals are taken on a case by case basis, taking into consideration the totality of the information related to the cases concerned. This will include reports under Rule 35(1) submitted by healthcare professionals working in Immigration Removal Centres.

As stated above, in our view the Minister has not satisfactorily answered the question:

1. It is correct that Rule 35(1) DCR reports require medical practitioners working in immigration removal centres (IRCs) to report to the centre manager (who must in turn report to the Home Office) on any detainee whose health is likely to be injuriously affected by continued detention or conditions of detention. However, there are questions of degree: there are those whose health, including mental health, which may be injuriously affected by continued detention or conditions of detention but for whom doctors consider may be treated or managed appropriately in detention; and there are those whose medical needs a doctor considers cannot be met in detention. In the latter case, the doctor is likely to say in terms that the detainee is unfit for detention (our members have seen many such reports). It appears that it is the latter type of case with which your question is directed, where clearly decisions not to release should be carefully scrutinised to ensure that the Home Office is acting lawfully, both in terms of its policy on detention[1] and its obligations under the European Convention on Human Rights.[2]

2. It is the experience of our members that in many cases assessments by doctors that detainees are medically unfit for detention are not reported at all to the Home Office or are not reported by way of a Rule 35(1) DCR report. For example, our members have come across a number of cases at Harmondsworth and Colnbrook IRCs where reports that detainees are unfit for detention are made using a form known as a form IS91RA Part C. In one recent case, which is the subject of ongoing judicial review proceedings, no less than six assessments that the detainee was medically unfit for detention were reported to the Home Office on IS91RA Part Cs. In another recent case, three assessments by doctors that the detainee was unfit for detention were not communicated to the Home Office at all. In both cases, the High Court stepped in and ordered release.

There are important differences between IS91 RA Part Cs and Rule 35(1) DCR reports:

(a) The purpose of the IS91RA Part C is to report any change in the risk that detainees present to the Home Office's Detainee Escorting and Population Management Unit (DEPMU) in order for decisions to be made about <u>where</u> they should be detained, rather than <u>whether</u> they should be <u>released</u> from detention - see Chapter 55.6.1 of the Enforcement Instructions and Guidance:

Risk assessment is an ongoing process. Should further information become available to the LIT which impacts upon potential risk (either increasing or decreasing risk) during a detainee's detention, that

[1] See Chapter 55.10 of the Enforcement Instructions and Guidance, which provides for example that those with serious medical conditions which cannot be satisfactorily managed in detention should only be detained in "very exceptional circumstances":
http://www.bia.homeoffice.gov.uk/sitecontent/documents/policyandlaw/enforcement/detentionandremovals/chapter55.pdf?view=Binary

[2] It is worth pointing out that since August 2011 there have been four cases in which the High Court has found the immigration detention of mentally ill men at IRCs to constitute inhuman and degrading treatment in breach of article 3 ECHR: *R (S) v SSHD* [2011] EWHC 2120 (Admin) (5 August 2011), *R (BA) v SSHD* [2011] EWHC 2748 (Admin) (26 October 2011), *R (HA) v SSHD* [2012] EWHC 979 (17 April 2012), *R (D) v SSHD* [2012] EWHC 2501 (Admin) (20 August 2012).

information should be forwarded to DEPMU using form IS91RA part C. On receipt of this form (which can also be completed by other Home Office or removal centre management/medical staff) DEPMU will reassess risk and reallocate detention location as appropriate. Any alteration in their assessment of risk will require a new IS91 to be issued on which up-to-date risk factors will be identified. The LIT must fax this new IS91 to the detention location on receiving DEPMU's reassessment of alteration in potential risk.

(b) By contrast, a Rule 35(1) report triggers an obligation on the Home Office to conduct a formal review of detention, considering the contents of the report against its policy on detention, and send a formal response, within two working days, to the detainee and release if detention is no longer appropriate – see the Home Office policy, "Detention Rule 35 Process":[3]

The Rule 35 report must be considered and responded to as soon as possible, but no later than the end of the second working day after the day of receipt. (See table, below, which assumes a normal working week - no public holidays etc.) […]
Consideration, Detention Review, Release/Maintain Detention
· Carefully consider the report (for 35(3) reports, see 3 Rule 35(3) Responses - Handling); […]
· Consider the issues raised, and conduct a detention review in line with published detention policy;
· Take prompt action to release the detainee if appropriate (which will include if the report amounts to independent evidence of torture and if no very exceptional circumstances apply); […]
Response
· Every Rule 35 report must receive a written response, even if the detainee has been or will be released. A response in released cases may be very brief;
· Holding responses are not acceptable. Responses must always be returned on time, regardless of other events close to the deadline (e.g., a forthcoming asylum interview or action under the Dublin Regulation)…

3. Finally, in our view the Minister should have broken down the numbers of those released to distinguish (a) those released by the Home Office and (b) those released as a result of orders by courts and tribunals.

We would be happy to discuss the issues we have raised in this letter further.

We are sending a copy of this letter to the Minister, the Home Affairs Select Committee, Her Majesty's Chief Inspector of Prisons and the Harmondsworth and Colnbrook Independent Monitoring Boards.

Yours sincerely

Dr Hilary Pickles
Chair, Mental Health in Immigration Detention Action Group

Copies to:
Lord Taylor of Holbeach, parliamentary under secretary, Home Office, 2 Marsham Street, SW1P 4DF
Secretary, Home Affairs Select Committee, House of Commons, 7 Millbank, London SW1P 3JA
Her Majesty's Chief Inspector of Prisons, First Floor, Ashley House, 2 Monck Street, SW1P 2BQ
Chair, Colnbrook IMB, Colnbrook IRC, Colnbrook Bypass, Harmndsworth, West Drayton, UB7 0FX
Chair, Harmondsworth IMB, Colnbrook Bypass, Harmondsworth, West Drayton, UB7 0HB

[3] http://www.bia.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumprocessguidance/detention/guidance/rule35reports.pdf?view=Binary

Appendix 10

How many immigration detainees get sectioned under the Mental Health Act ?

Responses to requests made under the Freedom of Information (FOI) Act

Immigration detainees who have their mental health deteriorate to the extent that they require admission to hospital under the Mental Health Act (MHA) are just the tip of the ice-berg, but still important to quantify. There are no routinely published statistics on this, so MHIDAG members have tried using the FOI to extract information. This reports on the responses received to date.

Those who might expect to have this information were judged to be:

- The Home Office, who are responsible for immigration detainees
- The Ministry of Justice (MoJ) who are expected to approve transfers made under s48 of the MHA
- NHS England who commission placements for immigration detainees who require hospital treatment, whether in the NHS or in private sector providers
- NHS bodies who manage these placements under the MHA

The responses to previous FOI requests have not always been helpful. The reply to a question from Dr Adeline Trude (BiD) made 8th Nov 2011 and sent by the UKBA on 1st Dec 2011 said the information was held by their healthcare departments but would exceed the £600 cost limit to answer [their ref FOI 20591]. A reply to BiD from the MoJ at that time said: "between 1 January 2009 and 31 August 2011, the Secretary of State received 40 applications for the transfer of persons detained under immigration powers. In 37 of these cases, he made a transfer direction under s48(2)(d) of the 1983 Act. The Secretary of State did not decline any such request for transfer direction. In three cases, the request was withdrawn because the detainee's mental health had improved to the extent that treatment in hospital was no longer required". They pointed out that for transfers under s2/3 were outside their remit but the information may be held by the Home Office [their ref: FOI 73071].

The format of the questions this time reflected that past history and also the responsibilities of the body being approached.

body	ref	FOI date	1st FU	2nd FU	Ackn?	response	inaccuracies
Home Office	29372	21/06	07/08	19/10	22/10	18/11	PCTs still responsible for secondary healthcare
MoJ	?	08/08	09/09/	?	no	no	[received 09/09 and acknowledgment promised but not sent]
NHSE	SDR-99161	21/06	23/07	02/09	25/06 24/07 03/09	11/09	Costs were for Home Office, but also contracts for 2013/14 were agreed by CCGs. Errors compounded in further correspondence
CNWLT	13FOI 165	30/09	Explanation for delay in reply accepted		01/10	05/11	Ambiguous response. Assumed correct (and different) information received 07/11

Home Office

Question asked by Dr Hilary Pickles. "*How many people detained under the Immigration Acts in immigration removal centres (IRCs) are transferred each year to hospital following sectioning under the Mental Health Act from (a) Colnbrook, (b) Harmondsworth, (c) Yarl's Wood and (d) all other IRCs?*

The answer in FOI 17449 from Feb 2011 was that this sort of information was not collated centrally, and so could not be provided except at disproportionate cost. If that remains the case, how are such absences from IRCs registered in the returns made by the IRCs to the UKBA/Immigration Enforcement Directorate used for the optimal management of the detention estate? Initially asked on-line on 21st June 2013, and followed in writing by hard copy on 7th August 2013, with not even an acknowledgement either time. Followed up with a complaint on 19th October, which received an acknowledgement and a response promised 'in due course' [their ref 29372].

The final response received 18th Nov ignored the earlier requests and responded to the 'complaint' version of the question, i.e. *'Can we quantify how many immigration detainees have their mental health deteriorate to such an extent that they need to be transferred to hospital under section of the Mental health Act?'*. The response was: *'The number of individuals who have left the immigration detention estate having been sectioned under the Mental health Act is detailed in the table below, broken down by year since 2010.*

year	Sectioned under the Mental Health Act
2010	20
2011	8
2012	19
2013 quarter 1 2013 quarter 2	1 2

All detainees have access to secondary healthcare services, including mental health provision. Responsibility for providing secondary healthcare treatment for immigration detainees rests with Primary Care Trusts (PCT), including hospitalisation of those with acute mental health illness. These cases are given priority and we try to ensure that anyone who is in need of assessment and removal to an appropriate environment is relocated as soon as possible. If a medical practitioner believes that the detainee requires sectioning under the Mental Health Act they will apply to the local PCT to provide a suitable bed.

In subsequent correspondence it was confirmed the figures were to the end of June 2013 and was pointed out that PCTs had been abolished in April 2013 and NHS England now was responsible for the commissioning.

Ministry of Justice

Request made by Adeline Trude in early August 2013 by e-mail and repeated 9th September using the online form. Automatic message saying this had been received and would be acknowledged, but no more.

Please supply me with the following information: The number of requests for transfer to a secure mental health facility i) received, the number of transfer directions ii) approved, iii) declined, iv) otherwise disposed of by the Secretary of state under s48 of the Mental Health Act in relation to immigration removal centres in the UK. Please supply information covering all such requests received within the following periods a) 1st January 2009 to 31st December 2009, b) 1st January 2009 to 31st December 2010, c) 1st January 2009 to 31st December 2011. You have previously supplied this information to me in relation to a slightly different period (Your ref: FOI 73071). Please supply information electronically via my e-mail address listed below. I look forward to hearing from you promptly, as required by the legislation, and in any case within 20 working days.

NHS England

Request made by Dr Hilary Pickles 21st June 2013, acknowledged soon after, but then no reply. So chased 23rd July, and again 2nd September.

I am interested in the number of people who had been detained under the Immigration Acts in Colnbrook, Harmondsworth and Yarl's Wood IRCs who were transferred to NHS hospitals under MH section. I am unclear of the contracting currencies being used but ask for information on (a) the number of immigration detainees who have been newly placed under section in NHS mental health units since NHSE took over commissioning responsibility for such care and/or (b) those who are currently under section and/or (c) the

packages of mental health care under section charged to NHSE for immigration detainees since April 2013 and/or (d) the number of places reserved in the NHS for detainees under section.

When will information become available on the costs to NHSE of treating immigration detainees under MH section for the first quarter of 2013/14?

When agreeing contracts for 2013/14, if estimates were used for the average number of places for immigration detainees requiring section in 2013/14 in order to commission such care, on what basis were those estimates made?

If the healthcare needs assessment commissioned from the Central and North West London Trust on immigration detainees has been completed, can it be made available please?
The response on 11th September [their ref: SDR-99161] was: *With regard to questions a,b,c, and d, please can I advise that NHS England does not routinely record this information. However, I can confirm that for the following Trusts, there have been no admissions from IRCs under the Mental Health Act* (then they list 8 mental health trusts in London, including Central and North West London Foundation Trust).

On costs: *NHS England do not hold this information. NHS England are currently in the process of transferring responsibility for the commissioning of healthcare from the Home Office and therefore are at this time unable to provide this information. However, please can I advise that it is likely that these arrangements will be finalised by September 2014, and NHS England may therefore be in a better position to advise you on this information after that time.*

On contracts: *NHS England did not agree contracts for 2013/14. This responsibility sits with the local Clinical Commissioning Group, who may be able to assist you further in this enquiry*

The HNA on Colnbrook and Harmondsworth was provided. This indicates that 2 places in Colne ward are regarded as reserved for immigration detainees.

The IRC lead in national NHS England (Christine Kelly) was alerted by e-mail on 11th September to the mistake in implying CCGs commission such care, clarifying it was transfers under s48 not s2/3 that were being asked about. Also the transfer from the Home Office was irrelevant to care in hospital which had always been for commissioning by the NHS. With the continued confusion about responsibilities and difficulties experienced by a client of Bhatt Murphy's, and after a meeting with Christine, a letter was sent in complaint by Hilary Pickles on 10th October 2013. A partial response received on 3rd Nov compounded the confusion by explaining that the current contracts for 2013/14 were pulled together by CCGs in shadow form running alongside PCTs in 2012/13 and implying that the UKBA was the responsible body for the contracts at that time. It was also confirmed that if the detainee needed a secure setting, it would be commissioned by specialist commissioning in NHSE, and if psychiatric services in acute settings, this would indeed sit with Health and Justice. A further e-mail to NHSE pointed out that the Home Office never picked up the costs of secondary care, even for those IRCs that fell under NOMS.

A more formal response to the complaint was made by NHSE on the 19th Nov. The explanation remained unconvincing, relating to a misunderstanding on the premise of the question and so responded on the timeline for transfer of commissioning from the Home Office. An update on that was *'we are about to start procuring the healthcare services in partnership with the Home Office which will facilitate the move to NHS England contracting arrangements. This is to be delivered by 1st September 2014 and until that time the healthcare services will remain the responsibility of the Home Office'.* NHSE explained the request about the delay in a recent case had been passed to the Home Office.

Writing back it was pointed out that the failure to provide a place was down to the NHS not the Home Office, so it was inappropriate to pass the issue on to them. It was confirmed with the FOI office that queries in this subsequent correspondence were not expected to be handled under the FOI rules.

The conclusion on the correspondence with NHSE is of considerable confusion, with responses which are internally inconsistent as well as incorrect, and excuses that are unconvincing.

Central and North West London NHS Foundation Trust (CNWLT)

Request made by Hilary Pickles 30th September 2013. *How many people have been newly admitted to*

CNWLFT from immigration removal centres (IRCs) under the Mental Health Act (transfers or admissions) so far in financial year 2013/14 and how many individuals/transfers took place in 2012/13. If you have other information on the average number of immigration detainees being treated as inpatients (there are said to be 2 'reserved' beds in Colne ward) that would be useful too. The response received on the 5th November, after an apology for the delay caused by illness, was: *I have been advised that in 2012/13 two patients were admitted and since April, we have had seven admissions to Colne ward recorded from Penal Establishments, Court or Police Stations. Unfortunately, we are unable to break this down further* [their ref 13 FOI 165].

An e-mail was sent asking for clarification on the sources of admissions in 2012/13 and pointing out that IRCs were not penal establishments etc. A reply on the 7th Nov direct from the Colne ward manager was that there had been one admission in 2013 so far, and in previous years the numbers were 2012-8; 2011-8; 2010-9; 2009-3. It was also said that in 2013 there had been 4 admissions from penal establishments, 2 from the police station and 1 from the Court.

Colne ward has been asked the date of the admission in 2013, in order to check whether the discrepancy with the NHSE reply of no admissions could just be a matter of timing.

Messages to take from these FOI responses

- The process of answering requests under the FOI is highly unsatisfactory. None of the bodies asked produced a reply meeting the accepted deadlines. There have been errors and/or ambiguities in all the replies received, at least in the initial responses. That said, all have been friendly and courteous and tried to be helpful, apart from the Ministry of Justice which has failed to reply at all
- Comment to the Information Commissioner may be appropriate
- The Home Office now has collated figures which in 2011 it said were not available.
- NHS England does not collate figures centrally
- The main receiving hospital for mentally-ill male detainees has admitted fewer patients this year than expected
- Overall, the admissions for 2013 are fewer than might be expected on historic trends
- NHS England is confused about responsibilities for commissioning MHA placements for immigration detainees, both historically and at present
- Clarification is needed urgently for their own staff and partners

<u>Possible reasons for the small numbers of immigration detainees sectioned under the MHA this year</u>

- False and incomplete data, with lags in the system?
- Chance, and within the range seen in 2011?
- Change in numbers and case-mix of detainees (although available data suggest both need and numbers are increasing)?
- Change in the threshold for serious mental illness which cannot be satisfactorily managed within detention, so fewer referrals made?
- Confusion about responsibilities for the commissioning of such care, especially post April 2013?
- Pressure on beds such that detainees are losing out to competition from other patients[39]

Appendix 11

References

1. Aliverti A (2012) Making people criminal. The role of the criminal law in immigration enforcement. *Theoretical Criminology* 2012;16:417-434

2. Amaral P for Jesuit Refugee Service-Europe (2010). Becoming vulnerable in detention. Civil Society Report on the Detention of Vulnerable Asylum Seekers and Irregular Migrants in the European Union (The DEVAS Project).on www.jrseurope.org

3. Arnold F, Beeks M, Fluxman J, Katona C, deZuletta F. Unmet medical needs in detention. *BMJ* rapid response 2006

4. Bacon L, Bourne R, Oakley C, Humphreys M. Immigration Policy: implications for mental health services *Advances in Psychiatric Treatment* 2010;16:124-132

5. Bail for Immigration Detainees 2012 The Liberty deficit: long-term detention & bail decision-making on www.biduk.org

6. Barnoux M and Wood J The specific needs of foreign national prisoners and the threat to their mental health from being imprisoned in a foreign country *Aggression and Violent Behaviour* 2013; 18: 240-246

7. Bhui K and Bhugra D 2002 Mental Illness in Black and Asian ethnic minorities: pathways to care and outcomes. *Advances in Psychiatric Treatment* (2002) 8: 26-33

8. Blinder S (2012) Deportations, Removals and Voluntary Departures from the UK on www.migrationobservatory.ox.ac.uk/sites/files/migobs/Briefing-Departures.pdf

9. Bostock W W (2009) The psychiatric profession and the Australian government: the debate over collective depression syndrome among asylum-seeking detainees. *Psychology Research and Behaviour Management* 2009: 2; 121-127

10. Bosworth M (2011) Immigration Detention: Policy Challenges on www.migrationobservatory.ox.ac.uk/sites/files/migobs/Immigration%20Detention%20Policy%20Primer.pdf

11. Bosworth M and Kellezi B Developing a Measure of the Quality of Life in Detention. *Prison Services Journal* 205; 2013:10-15 on www.crimeandjustice.org.uk/opus1989/PSJ_January_2013_No._205.pdf

12. Bracken P and Gorst-Unsworth C (1991) The mental state of detained asylum seekers. *Psychiatric Bulletin* 1991;15:657-659

13. Bradley 2009) The Bradley Report. Lord Bradley's review of people with mental health problems or learning disability in the criminal justice system. On www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694 (accessed 28 Feb 2013)

14. Brooker C and Ullmann B (eds) (2008) Out of sight, out of mind. The state of mental healthcare in prison. Policy Exchange on www.dhcarenetworks.org.uk/_library/Out_of_sight_out_of_mind.pdf

15. Canton R and Hammond N 2006 Foreigners to Justice? Irregular migrants and foreign national offenders in England and Wales *Eu J of Probation*; 4: 4-20

16. Central and North West London Foundation Trust. Colnbrook and Harmondsworth IRC health needs assessment May 2013

17. Cleveland J (2013) Psychological harm and the case for alternatives *Forced Migration Review* 2013;44:7-8

18. Cleveland J and Rousseau C (2012) Mental health impact of detention and temporary status for refugee claimants under Bill C-31. *Canadian Medical Association Journal* 2012;184:1663-1664

19. Cleveland J, Rousseau C (2013) Psychiatric Symptoms associated with brief detention of adult asylum seekers in Canada *Canadian Journal of Psychiatry*; 58:409-416

20. Coffey GJ, Kaplan I, Sampson RC, Tucci MM. The meaning and mental health consequences of long-term immigration detention for people seeking asylum. *Social Science and Medicine* 2010;70:2070-2079

21. Cohen J (2008) Safe in our hands?: A study of suicide and self-harm in asylum seekers. *J Forensic and Legal Medicine* 15: 235-244

22. Cooney F (2013) Double punishment: the treatment of foreign national prisoners *Prison Services Journal* 2013;205:45-51

23. Count me in census 2010. Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales on http://www.cqc.org.uk/sites/default/files/media/documents/count_me_in_2010_final_tagged.pdf

24. CPT (2009)- European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment- report on the visit to the UK on www.cpt.coe.int/documents/gbr/2009-30-inf-eng.pdf

25. Crichton E 2013 Transferring healthcare for immigration detainees in England to the NHS: complaint mechanisms www.bmj.com/content/346/bmj.f1884/rr/638684

26. Cutler S (2005) Fit to be detained? Challenging the detention of asylum seekers and migrants with health needs. Bail for Immigration Detainees on www.biduk.org

27. Das v SSHD [2013] EWHC 682 (Admin)

28. Dosani S re transferring healthcare for immigration detainees in England to the NHS *BMJ* 2013 on bmj.f1884/rr/641364

29. EU Receptions Conditions Directive 2013

30. Farrell J and Pennington J Recent Developments in immigration detention and the law in *Legal Action law and practice*; July/August 2013:24-30

31. Fili A (2013) The maze of immigration detention in Greece: a case study of the Athens airport detention facility. *Prison Service Journal* 2013;205:34-38

32. Fordham M (2011) A Refresh Health Needs Assessment of Adults Detained in Yarls Wood Immigration Removal Centre (IRC) NHS Bedfordshire

33. Gatwick Detainee Welfare Group (2012) A prison in the Mind: the mental health implications of detention in Brook House Immigration Removal Centre on www.gdwg.org.uk/downloads/GDWG-PrisonInTheMind.pdf

34. Glover G 2008 Estimating the prevalence of common mental health problems in PCTs in England on http://data.gov.uk/dataset/mental_health_-_prevalence_of_common_mental_health_problems

35. Goldwyn C. Many detainees shouldn't be there in the first place *BMJ* 2013;346:f2365

36. Green J P and Eagar K The health of people in Australian immigration detention centre *MJA* 2010;192: 65-70

37. Hallas P, Hansen A R, Staehr MA, Munk-Andersen E, Jorgensen HL. Length of stay in asylum centres and mental health in asylum seekers: a retrospective study from Denmark *BMC Public Health* 2007;7: 288 DOI: 1186/1471-2458-7-288

38. Harrison G (2002) Ethnic minorities and the Mental Health Act. *Br J Psychiatry* 2002;180:198-199

39. Health Committee (2013) First report. Post-legislative scrutiny of the Mental Health Act 2007 on www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/584/58405.htm#a7

40. HM Inspector of Prisons Foreign national prisoner: a follow up report 2007 www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/thematic-reports-and-research-publications/foreign-national-prisoners

41. HM Inspector of Prisons. Report of an unannounced short follow up inspection of Tinsley house 13-15 July 2009

42. HM Inspector of Prisons Report of a full announced inspection of. Brook House 15-19 March 2010

43. HM Inspector of Prisons Report on an unannounced full follow-up inspection of Colnbrook Immigration Removal Centre and short term holding facility 16-27 Aug 2010. 2011 on www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/immigration-removal-centre-inspections/colnbrook

44. HM Inspector of Prisons Annual Report 2010-11 on www.justice.gov.uk/publications/corporate-reports/hmi-prisons/hmip-annual-report-2010-11

45. HM Inspector of Prisons (Nick Hardwick) Report on an announced inspection of Yarl's Wood Immigration Removal Centre July 2011 www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/immigration-removal-centre-inspections/yarls-wood

46. HM Inspector of Prisons Report on an unannounced full follow-up inspection of Harmondsworth immigration removal Centre 14-25 Nov 2011. 2012 on www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/immigration-removal-centre-inspections/harmondsworth

47. HM Inspector of Prisons Annual Report 2011-12 on www.justice.gov.uk/publications/corporate-reports/hmi-prisons/hmip-annual-report-2011-12

48. HM Inspector of Prisons & Independent Chief Inspector of Borders and Immigration. The effectiveness and impact of immigration detention casework 2012. ISBN: 978-1-84099-578-7

49. HM Inspector of Prisons (Nick Hardwick) Report on an announced full follow-up inspection of Tinsley House Immigration removal Centre 8-11 Oct 2012 (2013)

www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/immigration-removal-centre-inspections/tinsley-house

50. HM Chief Inspector of prisons. Report on an announced inspection of Morton hall immigration Removal Centre 4-8 March 2013

51. HM Chief Inspector of Prisons for England and Wales (2013) Annual report 2012/13 on http:www.justice.gov.uk/downloads/publications/corporate-reports/hmi-prisons/hm-inspectorate-prisons-annual-report-2012-13.pdf

52. Home Affairs Committee 2012. The work of the UK Border Agency on www.publications.parliament.uk/pa/cm201213/cmselect/cmhaff/603/60305.htm

53. Home Affairs Committee 2013 on www.publications.parliament.uk/pa/cm201213/cmselect/cmhaff/792/792.pdf para 62

54. Home Office/UKBA Enforcement Instructions and Guidance (EIG, chapter 55.10) version 9

55. Home Office/UKBA Enforcement Instructions and Guidance (EIG, chapter 55.10) version 10

56. Ichikawa M, Nakahara S, Wakai S (2006) Effect of post-Migration Detention on mental health among Afghan asylum seekers in Japan. *Aust N Z J Psychiatry*;40:341-346

57. Immigration Law Practitioners' Association (ILPA) Briefing on the legal basis for immigration detention…and…transfers under the Mental Health Act 2008 Dec 2012 on www.biduk.org/827/news/

58. Independent Monitoring Board. Annual report for Harmondsworth Immigration Removal Centre 2011 on www.imb.gov.uk/annual-reports/index.htm

59. Independent Monitoring Board. Annual report for Harmondsworth Immigration Removal Centre 2012 on www.justice.gov.uk/downloads/publications/corporate-reports/imb/annual-reports-2012/harmondsworth-2012.pdf

60. Inegbenebor D, Sagba F K, Stevenson J, Sinyemu E, Kamara M for the African Health Policy Network. 'I'd rather be in prison' Experiences of Africans in Immigration Removal Centres in the UK 2012 on www.ahpn.org/Upload/page/97_AHPN_IRC_Research_Summary_Report_18.pdf

61. Keller A S, Rosenfeld B, Trinh-Shevrin C et al Mental health of detained asylum seekers *Lancet* 2003;362: 1721-1723

62. Kotsioni I, Ponthieu A, Egidi S (2013) Health at risk in immigration detention facilities. *Forced Migration Review* 2013;44:11-13

63. Launer J Transferring healthcare for immigration detainees in England to the NHS *BMJ* 2013 bmj.f1884/rr/638431

64. London Detainee Support Group (Jan 09) Detained lives: the real cost of indefinite immigration detention on www.detainedlives.org

65. Marshall T, Simpson S, Stevens A (2000) Health care in prisons: a health care needs assessment on https://www.bulger.co.uk/prison/needsassessmentbirmingac.pdf (accessed 28 Feb 2013)

66. Matrix Evidence. (2012) An economic analysis of alternatives to long-term detention on http://detentionaction.org.uk/timelimit

67. McGinley A and Trude A Positive duty of care? The mental health crisis in immigration detention. A briefing paper by the Mental health in Immigration Detention Project May 2012. AVID (association of visitors to immigration detainees) and BiD (Bail for Immigration Detainees) on www.aviddetention.org.uk/images/positive%20duty%20of%20care%20final.pdf

68. McGinley A Transferring healthcare for immigration detainees in England to the NHS *BMJ* 2013 bmj.f1884/rr/638594

69. Medical Justice (2013) Expecting change: the case for ending the detention of pregnant women on www.medicaljustice.org.uk

70. Mental health bulletin Sixth report from Mental Health Minimum Dataset returns - England 2011/12, initial national figures on https://catalogue.ic.nhs.uk/publications/mental-health/services/ment-heal-bull-mhmds-anua-retu-2011-12/meant-heal-bull-mhmds-anua-retu-2011-12-bulletin.pdf

71. Migration Observatory (2013) Migration in the news: portrayals of Immigrants, Migrants, Asylum Seekers and Refugees in National British Newspapers 2010-2012 on www.migrationobservatory.ox.ac.uk/sites/files/migobs/Report%20-%20migration%20in%20the%20news.pdf

72. Mind (2009) A civilised society. Mental health provision for refugees and asylum-seekers in England and Wales on www.mind.org.uk/assets/0000/5695/refugee_report_2.pdf

73. MIND prevalence of common mental health disorders on www.mind.org.uk/assets/0001/4315/Prevalencve.JPG

74. Moylan J (2013) Desperation, Displacement and Detention: Australia's Treatment of Asylum Seekers Past and Present. *Prison Services Journal* 2013;205:16-22

75. Mueller J, Schmidt M, Staeheli A, Maier T Mental health of failed asylum seekers as compared with pending and temporarily accepted asylum seekers. *European Journal of Public Health* 2010; 21: 184-189

76. National Preventive Mechanism. Monitoring places of detention. First annual report 2009-10 Cm 8010 Feb 2011 ISBN 9780 101801027 on www.official-documents.gov.uk

77. National Preventive Mechanism. Monitoring places of detention. Second annual report 2010-11 Feb 2012 on www.official-documents.gov.uk

78. NICE Commissioning stepped care for people with common mental health disorders. Commissioning Guide Nov 2011 on http://publications.nice.org.uk/commissioning-stepped-care-for-people-with-common-mental-health-disorders-cmg41/3-a-stepped-care-approach-to-commissioning-high-quality-integrated-care-for-people-with-common

79. No-deportations. Self-Harm in Immigration Detention January through December 2012 on www.no-deportations.org.uk/Media-1-2012/Self-Harm2012.html

80. Ochoa K, Pleasants G, Penn J, Stone D. Disparities in justice and Care: Persons with severe mental illness in the US Immigration Detention System *J Am Acad Psychiaty Law* 2010;38:392-9

81. Phillimore J, Ergün E, Goodson L, Hennessy D. Refugee well being and mental health April 2007. Joseph Rountree Foundation/University of Birmingham

82. Phillips C B Immigration detention and health *MJA* 2010;192:61-62

83. Physicians for Human rights. Dual Loyalties: The Challenge of Providing Professional Health Care to Immigration Detainees. 2011 on physiciansforhumanrights.org

84. Physicians for Human Rights (2013) Indefinite Detention. Submission to the Human Rights Committee During its consideration of the Fourth Periodic Report of the United States on physiciansforhumanrights.org

85. Pickles H Colnbrook and Harmondsworth Immigration Removal Centres Health Needs Assessment 2010 on medicaljustice.org.uk/general-information/reports/1937-hillingdon-pct-health-needs-assessment-for-detainees-at-Colnbrook-and-Harmondsworth-feb-2010.html

86. Pickles H & Hartree N. Transferring healthcare for immigration detainees in England to the NHS. *BMJ* 2013;346:f1884

87. Plugge E, Baugh V, Beck K, Kyuvi A, McLaren E (Dec 2009) A rapid health needs assessment of detainees at Campsfield Immigration Removal Centre, Oxfordshire

88. Pourgourides C A second exile: the mental health implications of detention of asylum seekers in the UK *Psychiatric Bulletin*1997;21:673-674

89. Prison Mental Health. Mental health primary care in prisons. Groups with special needs Black and other ethnic minorities – including foreign national prisoners and immigration detainees on www.prisonmentalhealth.org/dowloads.html (accessed 22 Feb 2013)

90. Prison Reform Trust (2007) Unjust deserts (on the impact of indefinite detention)

91. The Prison Rules 1999 on http://www.legislation.gov.uk/uksi/1999/728/article/21/made

92. Prisons and Probation Ombudsman. Report of the inquiry into the disturbance and fire at Yarls Wood Removal Centre. Oct 2004

93. R (BA) & SSHD [2011] EWHC 2748 (Admin) on www.bailii.org/ew/cases/EWHC/Admin/2011/2748.html

94. R (D) v SSHD [2012] EWHC 2501 (Admin)on www.bailii.org/ew/cases/EWHC/Admin/2012/2501.rtf

95. R (HA (Nigeria)) & SSHD [2012] on http://www.bailii/org/ew/cases/EWHC/Admin/2012/979.htm

96. R (LE Jamaica) v SHHD [2012] EWCA Civ 597

97. R (S) & SSHD [2011] EWHC 2120 (Admin) on www.bailii.org/ew/cases/EWHC/Admin/2011/2120.html

98. R (T) & SSHD [2010] EWHC 668 (Admin) on www.bailii.org/ew/cases/EWHC/Admin/2010/668.html

99. Robjant K, Hassan R, Katona C (2009). Mental health implications of detaining asylum seekers: systematic review. *Br J Psychiatry* 194: 306-312

100. Robjant K, Robbins I, Senior V. (2009) Psychological distress amongst immigration detainees: a cross-sectional questionnaire study. *Br J Clin Psychol*; 48: 275-286

101. Royal College of General Practitioners and Royal College of Psychiatrists Forum. Guide to providing Mental Health Care Support to Asylum Seekers in Primary care

102. Royal College of Paediatrics and Child Health, Royal College of General Practitioners, Royal College of Psychiatrists, Faculty of Public Health (Dec 2009). Intercollegiate Briefing Paper: significant harm – the effects of administrative detention on the health of children, young people and their families. On: www.rcpsych.ac.uk/pdf/significant%20harm%20intercollegiate%20statement%20dec09.pdf (accessed 28 Feb 2013)

103. Royal College of Psychiatrists (2013) Position statement on detention of people with mental disorders in Immigration Removal Centres www.rcpsych.ac.uk/policyandparliamentary/projects/live/asylumseekers.aspx = appendix 5

104. Sampson R, Mitchell G and Bowring L (2011). There are alternatives: A handbook for preventing unnecessary immigration detention. Melbourne. The International Detention coalition on www.idcoalition.org

105. Sargeant L & Kitcat J (Feb 09) Oakington Immigration Removal Centre Health Needs assessment, for NHS Cambridgeshire

106. Spurrier M Transferring healthcare for immigration detainees in England to the NHS. *BMJ* 2013 bmj.f1884/rr/638590

107. Spurrier M and Willman S Mental health and immigration detention post-*HA* Legal Action law and practice July/Aug 2013 31-34

108. Steel Z, Momartin S, Silove D, Coello M, Aroche J, Tay KW. Two year psychological and mental health outcomes for refugees subjected to restrictive or supportive immigration policies *Social Science and Medicine* 2011; 72: 1149-1156

109. Steel Z, Silove D, Brooks R, Momartin S, Alzuhairi B and Susljik I. Impact of immigration detention and temporary protection on the mental health of refugees. *BJP* 2006; 188: 58-64

110. Tsangarides N The second torture: the Immigration detention of torture survivors 2012 www.medicaljustice.org.uk

111. UKBA Detention Centre Rules (2001) on www.legislation.gov.uk/uksi/2001/238 etc

112. UKBA Enforcement Instructions and Guidance 57.4 quoting para 30(2) of Sch 2 to the Immigration and Asylum Act 1971on http://bit.ly/uRubkQ

113. UKBA Enforcement Instructions and Guidance. 55.10 Persons considered unsuitable for detention (rule 35) on www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/enforcement/detentionandremovals/chapter55.pdf?view=Binary (accessed 11 Feb 2013)

114. UKBA healthcare standards. http://www.ukba.homeoffice.gov.uk/sitecontent/documents/managingourborders/immigrationremovalcentres/operatingstandards/operatingstandards_manual.pdf?view=Binary

115. Ward T (2011) Long-term health costs of extended mandatory detention of asylum seekers Yarra Institute for Religion and Social Policy on www.socialpolicyconnections.com.au/wp-content/uploads/2011/10/Ward.long-term-costs-v12Oct.2011.pdf

116. Weich S, Nazroo J, Sproston K et al (2004) Common mental disorders and ethnicity in England: the EMPIRIC study. *Psychological Medicine* 2004; 34: 1543-1551

117. Whalley R (2007) Report of the Investigation into the disturbances at Harmondsworth and Campsfield House Immigration Removal centres on www.official-documents.gov.uk/document/hc0607/0946/0946.pdf

118. Zimmerman S E, Chatty D, Nørredam M L Health needs and access to care in immigration detention: perceptions of former detainees. *International J of Migration, Health and Social Care* 2012; 8 :180-185

119. Lewis G and Meek R (2013) A comprehensive Health Needs Assessment of Prisons and IRCs on behalf of NHS England (London) obtained through FOI and on www.medicaljustice.org.uk

Appendix 12

List of abbreviations

ACDT	Assessment, care in detention and teamwork
AVID	Association of visitors to immigration detainees
BID	Bail for immigration detainees
CBT	Cognitive behavioural therapy
CCG	clinical commissioning group
DH	Department of Health
EIA	Equality Impact Assessment
EIG	Enforcement instructions and Guidance
FOI	Freedom of Information
GMC	General Medical Council
HMIP	Her Majesty's Inspector of Prisons
HRA	Human Rights Act
IE	Immigration Enforcement (part of Home Office, ex-UKBA)
IMB	Independent Monitoring Board
IRC	Immigration removal centre
LA	local authority
MH Act, MHA	Mental Health Act 2008
MHIDAG	Mental Health in Immigration Detainees Action Group
MoJ	Ministry of Justice
NAO	National Audit Office
NGO	non-governmental organisation
NHSE	NHS England (ex-NHS Commissioning Board)
NICE	National Institute of Health and Care Excellence
NOMS	National Offender Management Service
OCD	Obsessive compulsive disorder
PCT	Primary Care Trust
PPO	Prisons and Probation Ombudsman
PTSD	Post traumatic stress disorder
SEG	Secure Environments Group of the Royal College of General Practitioners (RCGP)
SSHD	Secretary of State for the Home Department
STHF	short term holding facility
UKBA	UK Border Agency

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Medical Justice

Medical Justice is a small charity that exposes and challenges inadequate healthcare provision to immigration detainees. We deal with approximately 1,000 individual detainee cases a year. Most of the work is carried out by volunteers, co-ordinated by four paid workers. We are the only organisation that focuses on arranging for independent clinicians to visit men, women and children detained, writing medico-legal reports documenting scars of torture and serious medical conditions. We help detainees to access competent lawyers who properly harness the strength of the medical evidence we generate.

Medical evidence from our casework feeds into our research and media work. We discuss policy changes with the Home Office to help secure lasting change. Where this fails, we may undertake strategic litigation.

If you would like to make a donation, our bank details are: CAF Account. Sort Code: 40-52-40. Account number: 00021167.

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