

Post : 86 Durham Road, London, N7 7DT

Website : [www.medicaljustice.org.uk](http://www.medicaljustice.org.uk)

Phone : 0207 561 7498

Fax : 08450 529370

## MENTAL HEALTH IN DETENTION

### Written evidence submitted by Medical Justice to the Shaw Review

- 1. Summary:** In the last 3 years there have been 6 court cases where the High Court has ruled the detention of a detainee with mental disorders ‘inhuman and degrading’. Detention is harmful to the health of detainees but the effects on those with mental disorders is especially harmful. Medical Justice (MJ) is concerned that current Home Office policy and practice fails to take into consideration the deleterious effect of detention on the mental health of detainees and the significant risk of deterioration. MJ is concerned by the systemic failure to identify mental disorders in IRCs; the lack of timely assessment; the failure to establish appropriate treatment plans and the failure of associated safeguards such as Rule 35. MJ believes that detention mitigates against the successful treatment of mental illness.
- 2. Background:** Every year, 30,000 people are held in Immigration Removal Centres (IRCs) and other facilities across the UK. MJ believes that:
  - IRCs, and the conditions of detention, are so detrimental to the health and wellbeing of those detained that the only way to remedy this situation is to close the IRCs.
  - all detainees must have access to NHS equivalent treatment.
  - vulnerable detainees should not be detained.
- 3. About Medical Justice:** Medical Justice is the only organisation in the UK to send independent volunteer doctors in to all the IRCs across the UK. The doctors document detainees' scars of torture and challenge instances of medical mistreatment. We see more than 600 cases each year and have gathered a sizeable, unique and growing medical evidence base. Evidence from our casework is the platform for our research into systemic failures in healthcare provision, the harm caused to detainees by these shortcomings, as well as the toxic effect of immigration detention itself. We and others use our research to secure lasting change to the detention regime through policy work, strategic litigation and by raising awareness of the conditions inside places of immigration detention.
- 4. Shortcomings in services:** There are serious shortcomings in detainees access to services within detention e.g. lack of access to legal advice (*BID briefing*<sup>[7]</sup>), failures of safeguarding mechanisms (*see MJ briefing on Rule 35*<sup>[8]</sup>) and general healthcare (*see MJ briefing on healthcare*<sup>[9]</sup>). This submission will focus on the shortcomings in mental health provision in IRCs. Research from across the world shows that migrants, due to pre and post migration stressors, have high rates of mental disorders<sup>[10, 11]</sup>. Despite this increased need, the provisions for mental health care in IRCs is less than that offered in the community. In addition, research demonstrates that detention is harmful to the health of detainees and is particularly detrimental to those suffering from mental disorders<sup>[12]</sup>, sometimes to the point of requiring hospitalisation. Despite guidelines stating that those “suffering from serious mental illness which cannot be satisfactorily managed within detention”<sup>[13]</sup> should only be considered suitable

for detention in very exceptional circumstances individuals with unmanaged mental health issues are still detained.

5. **Failure to identify vulnerable detainees with mental disorders:** This is in part due to an inadequate screening processes.

5.1 *Asylum Screening:* In fast-track cases, mental disorders could potentially be identified during the Home Office Screening interview where the basic details of an asylum claim are recorded. In non-fast track cases, the Home Office will frequently already hold information about the detainee's circumstances including any mental health problems. Where there is an indication in existing records that an individual may suffer from a mental health issue, this should be explored prior to a decision to detain. Justice Ouseley ruled in [Detention Action v SSHD] that because of *"deficiencies in the screening process (...) the process inherently cannot identify all the claims which are in fact unsuitable for detention or a quick decision"*<sup>[14:§112]</sup>.

5.2 *IRC health screening:* Mental disorders could be identified during the health screening at the IRC where all detainees should be seen by a nurse within 2 hours of arrival and be offered an appointment with a GP within 24 (Rule 34<sup>[15]</sup>). However, these health screenings are often short, conducted without the help of an interpreter, may take place in the middle of the night following long and exhausting transportation, and the distinctions between custodial and health staff is often unclear to the detainee. These conditions are not conducive to the disclosure of sensitive information such as mental health issues. There is no routine screening questions for PTSD despite this being a high risk population. Lastly, mental health issues could be reported through a Rule 35 report at any point during detention – the shortcomings in the Rule 35 process have been discussed in detail in a separate briefing<sup>[8]</sup>. HMIP *"found that detainees' mental health needs were under-identified, and staff described the inpatients department as a 'forgotten world'. There had been no mental health needs assessment, no staff training in mental health awareness and there was no counselling service, despite increasing numbers of detainees with high anxiety and low-level depression."*<sup>[16 p.67]</sup>

5.3 *Lack of training:* HMIP inspection of Yarl's Wood found that *"staff had no specific training in recognising and managing the particular vulnerability of the female population"*<sup>[17 p.13]</sup> and *"health services staff had not been trained in the recognition of torture or trauma"*<sup>[17 p.16]</sup>. Lacking proper training in the identification of mental health issues custodial and healthcare staff often fail to correctly identify mental illness and instead ascribe symptoms to behavioural issues – recording strange, unusual or bizarre behaviour in case files without questioning whether there may be underlying mental health issues accounting for such behaviour. In the Coroner's inquest into the death of Brian Dalrymple in detention one member of staff said she felt under-equipped to deal with such a vulnerable population whilst *"two officers said that they were not concerned about people in Harmondsworth "muttering to themselves", because a lot of people in Harmondsworth did that. It was accepted in questioning that might mean all those people were exhibiting signs of mental illness."*<sup>[18]</sup>. IRC providers often outsource GP services or rely on locum doctors who may not have received specialist training in recognising signs of trauma or torture and the inquest found that *"medical practitioners may be employed at Harmondsworth IRC without knowledge necessary to that role."*<sup>[19]</sup>

5.4 *Culture of disbelief:* A prevailing 'culture of disbelief'<sup>[20, 21]</sup> means that staff often ascribe behaviour indicative of mental disorders to intentionally disruptive or manipulative behaviour by detainees<sup>[22]</sup>. Such behaviour is managed through disciplinary sanctions such as removing the detainee from association and segregating them under rule 40 or rule 42 of the Detention

Rules<sup>[23]</sup>, despite the well-documented negative impact separation has on the physical and mental health of individuals detained in these conditions<sup>[24]</sup>.

6. **Lack of communication:** Lack of communication between healthcare, custodial staff and Home Office caseworkers means that relevant information may be missing from assessments or decisions about continued detention.

6.1 *Between Custodial and Healthcare staff:* The inquest into the death of Brian Dalrymple found that *“relevant and significant observations recorded by detention centre staff and others are not actively brought to the attention of relevant healthcare staff”*<sup>[19]</sup> In addition, there is a lack of clarity between the role of custodial and health staff in the management of mental health issues for detainees – e.g. self-harm and suicide is the responsibility of the Assessment Care in Detention Teamwork (ACDT)<sup>[25]</sup> which is operated by custodial staff rather than healthcare staff. There is also additional evidence that ACDT does not catch all those at risk and that the process itself is seen as invasive and damaging to its intended audience<sup>[26]</sup> Healthcare staff often do not partake in the ACDT process and, thus, cannot make the connection between self-harm/suicidal intentions and other symptoms.

6.2 *Between Home Office and Health Providers:* If the GP concludes that continued detention would be detrimental to the health of a detainee they should complete a Rule 35 report to alert the Home Office caseworker to this fact. However, there is common misconception that Rule 35 reports are only for victims of torture. Therefore, Rule 35 reports are often not completed for those whose health is injuriously affected by detention, instead alternative forms, such as IS91 part C, are used. However, these alternative forms are not shared with the Home Office case worker and do not lead to a mandatory review of detention<sup>[8]</sup>. In addition, very few Rule 35 reports result in the release of the detainee despite clinical evidence and the HMIP notes that *“there was no system to seek the opinion of an independent medical specialist and in some cases [Home Office] caseworkers, with no declared medical qualification, appeared to be making their own clinical judgements”*<sup>[27 p.19]</sup>

7. **Consequences of failure to identify mental disorder:** In the last 3 years there have been 6 separate court rulings finding that detainees suffering from mental disorders were subjected to “inhuman and degrading treatment” in IRCs in breach of Article 3 of the European Convention on Human Rights. Several of these were Medical Justice clients, including the most recent case of a women [MD v SSHD] who entered the UK with a valid visa, who had no history of mental illness before her detention, but subsequently became suicidal and psychotic during 17 months of detention<sup>[28]</sup>.

7.1 The recent verdict of the jury in the inquest into the death of Brian Dalrymple at Colnbrook IRC was that the death was “contributed to by neglect”. The inquest demonstrated that a failure to diagnose underlying mental health issues and delayed psychiatric assessment contributed to Mr Dalrymple’s eventual death from natural causes whilst held in segregation.

7.2 The Article 3 cases and deaths in detention are the extreme end of the spectrum, however, the shortcomings in mental health provisions in detention affects thousands of detainees every year. These failures come at a great cost to individuals and the detriment of their mental and physical health. Many continue to struggle with these issues long after they are released from detention with associated health costs and loss of productivity. There is an additional cost to society which can be seen in the increasing Home Office expenditure on compensation payments for periods of ‘unlawful detention’.

8. **Failure to establish appropriate treatment plans for mental disorders:** In August 2010 there was a subtle change in wording of the Enforcement Instruction and Guidance (chapter 55.10)<sup>[13]</sup> policy on detention of those with mental health issues. From stating that persons with mental illness would “normally be considered suitable for detention in only very exceptional circumstances” (version 9) the wording now reads “those suffering from serious mental illness which cannot be satisfactorily managed within detention” (version 10)<sup>[13]</sup>. While it was accepted that the original policy also included an implicit threshold of severity and for the detainee to be negatively affected by the combination of detention and his/her mental illness, the change in wording does reflect a change in Home Office practice over the last 5 years, from a presumption against the detention of individuals with mental health problems, to a presumption that most mental illness can be satisfactorily managed in detention. This has led to severely mentally ill detainees being detained and allowed to deteriorate until they become unmanageable. The inadequacies in mental health provision means that individuals can deteriorate very severely, without a meaningful review of their detention taking place. One client with known mental health issues that were considered manageable by the IRC was kept in detention and allowed to deteriorate to the point of almost dying before being transferred back to a psychiatric hospital.

8.1 The current wording hinges on key phrases such as ‘serious mental illness’ and ‘satisfactorily managed’. The Royal College of Psychiatrists Working Group on Asylum Seekers position paper on detention of people with mental disorders<sup>[29]</sup> examines each of these in detail and argues that:

8.1.1 in modern therapeutic models hospitalisation would only be recommended in extreme cases and there is a moral imperative (recognised in the Mental Health Act<sup>[30]</sup> and Mental Capacity Act<sup>[31]</sup>) that treatment should take place in the least restrictive environment possible. The Royal College of Psychiatrists therefore considers it “*inappropriate to define seriousness of mental illness on the basis of need for admission*” instead they recommend defining ‘person suffering from serious mental illness’ as “*a person with a mental disorder that significantly impairs their ability to engage constructively in society, to care for him/herself and /or to work. We believe it is likely that any person with mental disorder would deteriorate to a level of ‘serious mental illness’ in the conditions of detention, which would also be associated with an increased level of emotional suffering.*”<sup>[29 p.6]</sup>

8.1.2 ‘**Satisfactory Management**’: The Operating Standards 2003 states that “*All detainees must have available to them the same range and quality of services as the general public receives from the National Health Service.*”<sup>[32 p.34]</sup> The NHS places great emphasis on parity of esteem, giving equal importance to mental and physical conditions. Despite high rates of mental disorders among detainees<sup>[10, 11]</sup> – in particular anxiety, depression, self-harm and PTSD - the provision of mental health services in detention is inferior to that in the community. Current NHS mental health service is focused not just on the treatment of symptoms of mental disorder but on the recovery, relapse prevention and the successful reintegration in society of sufferers<sup>[29]</sup>. None of these conditions can be easily fulfilled in the immigration detention setting which is characterised by fear and uncertainty<sup>[33]</sup> and has been shown to have a deleterious effect on mental health and recovery rates<sup>[12]</sup>. It can never be appropriate to utilise detention as an alternative or equivalent to hospital as detention is not a therapeutic environment. Rather, it adds another layer of stressors: loss of liberty, uncertainty over deportation, unpredictable events, social isolation, fear of abuse by staff, riots, forceful removal, hunger strikes, self-harm, the indefinite period of detention, a culture of disbelief, and the absence of specialist psychiatric service. “*The very fact of detention (which, unlike imprisonment, has no punitive or retributive function) mitigates against successful treatment of mental illness*”<sup>[29 p.6]</sup>

9. **Accessing treatment:** Even when a detainee's mental disorder is identified there is often an unacceptable delay, sometimes months, before the detainee is properly assessed by a psychiatrist. In addition, when a detainee has been assessed by a qualified psychiatrist, either an IRC consultant or an independent psychiatrist, who concludes that continued detention is detrimental to the mental health of the detainee this does not necessarily result in release from detention. In practice, detention often continues in spite of several psychiatric reports recommending treatment outside of the detention setting, demonstrating that the burden of evidence required to secure access to treatment through release can be staggering. The current arrangements for authorising detention are inappropriate as Home Office caseworkers overrule clinical judgements without providing adequate evidence of very exceptional circumstances. One of the ways in which detainees with serious mental disorders receive treatment while detained, is for them to be transferred to a hospital under Section 48 of the Mental Health Act. Detainees should not be allowed to deteriorate to the point of requiring hospitalisation before being released from detention, and when discharged from hospital it is imperative that they are not returned to detention, unless there are very exceptional circumstances, as in many cases this environment will have contributed to their mental deterioration in the first place. Hospitalisation suggests a serious mental illness which cannot be satisfactorily managed in detention, and therefore release needs to be considered as it is preferably for detainees to be released to the care of a home treatment team or be admitted under Section 2 if necessary.
10. **Indefinite Detention:** MJ believes, in line with academic research<sup>[34]</sup>, that all immigration detention is harmful to the health of detainees, however, indefinite detention is particularly harmful<sup>[34]</sup>. Lack of insight into progress of their case and likely length of detention means that even detainees that are held for a relatively short period of time suffer the devastating psychological effects<sup>[35]</sup> and the wider human cost<sup>[36]</sup> of indefinite detention. MJ recommends that all IRCs are closed due to the widespread harm they cause but, as long as immigration detention continues to be used, there should be a time limit on the period of detention.
11. **Alternative to detention:** Detainees with mental disorders should not be detained but, as an alternative, released from detention unless there are very exceptional circumstances so that they can access mental health services in the community. This would improve the recovery rates, aid in reintegration into society and cut the cost to the public purse.

**Medical Justice, May 2015**

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