

**Mental Health and Immigration Detention Working Group:  
Response to *Immigration detention of persons with mental health problems*  
consultation**

Introduction

1. The Mental Health and Immigration Detention Working Group (MHIDWG) was set up in response to profound and on-going concerns about the ill-treatment of immigration detainees with mental health problems. The group is chaired by Dr Hilary Pickles, who has significant experience working in health policy as a doctor and for the Department of Health. The other members of the group are:

- 1) Professor Cornelius Katona, Consultant Psychiatrist, Royal College of Psychiatrists and Helen Bamber Foundation
- 2) Emma Mlotshwa, coordinator, Medical Justice
- 3) Theresa Schleicher, casework manager, Medical Justice
- 4) Lisa Incedon, finance and administration, Medical Justice
- 5) Martha Spurrier, barrister, Doughty Street Chambers
- 6) Stephanie Harrison QC, barrister, Garden Court Chambers
- 7) Sue Willman, Partner, Deighton Pierce Glynn Solicitors
- 8) Hamish Arnott, Partner, Bhatt Murphy Solicitors
- 9) Jed Pennington, solicitor, Bhatt Murphy Solicitors
- 10) Camilla Graham-Wood, solicitor, Birnberg Peirce and Partners Solicitors
- 11) Khuluza Mlotshwa, law student
- 12) Aisha Kabejja, ex-detainee and student
- 13) Ali Fiddy, lawyer, Mind
- 14) Adeline Trude, Bail for immigration detainees
- 15) Steve Symonds, lawyer previously practising in immigration law

2. The group's terms of reference are as follows:

*The Mental Health and Immigration Detention Working Group (MHIDWG) is a voluntary and unfunded group with a membership of lawyers, health professionals, ex-detainees and NGO workers.*

*The MHIDWG:*

- *is seriously concerned about the mental health of those held under Immigration Powers;*
- *considers that aspects of the current detention and healthcare policy and their current implementation are detrimental to the mental health of immigration detainees; and*
- *will be marshalling evidence and submissions to influence a change for the better for both individual detainees and detainees as a whole.*

*The MHIDWG will do its work through collaborative discussion and information exchange and through influencing external bodies.*

3. This response has been prepared in conjunction with the Royal College of Psychiatrists, Medical Justice, and the Helen Bamber Foundation, three of the other organisations invited to respond to the consultation.

Context

4. Findings consistently report high levels of mental illness among immigration detainees. High proportions of immigration detainees display clinically significant

levels of depression, post-traumatic stress disorder (PTSD), anxiety, intense fear, sleep disturbance, profound hopelessness, self-harm and suicidal ideation. In a study monitoring immigration detainees over a nine month period, 85 per cent reported chronic depressive symptoms, 65 per cent reported suicidal ideation, 39 per cent experienced paranoid delusions, 21 per cent showed signs of psychosis and 57 per cent required psychotropic medication.<sup>1</sup> In a study reported in *Forensic and Legal Medicine*, Juliet Cohen found that the estimated percentage of self-harming in Immigration Removal Centres during a twelve month period was 12.79 per cent, compared with between 5 and 10 per cent in the prison community.<sup>2</sup>

5. Approximately half of immigration detainees have claimed asylum during their immigration status proceedings.<sup>3</sup> Asylum seekers may have experienced trauma prior to their arrival in the United Kingdom and will therefore be at a greater risk of developing trauma-related mental health problems, including Post Traumatic Stress Disorder (PTSD). The evidence demonstrates that higher levels of depression, anxiety and PTSD are found in detained asylum seekers than in asylum seekers living in the community<sup>4</sup> and that for people with PTSD (especially those who have experienced detention and associated ill treatment), the IRC setting may be particularly threatening and likely to aggravate their PTSD symptoms.<sup>5</sup>
6. The negative effects of detention on mental health are compounded by the long-term or indefinite nature of immigration detention in the United Kingdom: approximately 10 per cent of detainees are detained for longer than 12 months. One study has shown that a higher proportion of those who had been detained in excess of six months met the diagnostic criteria for PTSD, depression and moderate to severe mental health related disability than those who had been detained for shorter periods or had not been detained at all.<sup>6</sup> Another study has found that “prolonged detention exerts a long-term impact on the psychological well being” of detainees.<sup>7</sup> The Royal College of Psychiatrists believes ‘that detention centres are likely to precipitate a significant deterioration of mental health in the majority of cases, greatly increasing both the suffering of the individual and the risk of suicide and self-harm’.<sup>8</sup>

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<sup>1</sup> “Mental health implications of detaining asylum seekers: systematic review”, *British Journal of Psychiatry* 2009, Katy Robjant, Rita Hassan and Cornelius Katona, p.307.

<sup>2</sup> “Safe in our hands? A study of suicide and self-harm in asylum seekers”, *Forensic and Legal Medicine* 2008, Juliet Cohen, p.237.

<sup>3</sup> Home Office Immigration Statistics, October – December 2011. Available at: <http://webarchive.nationalarchives.gov.uk/20130125092724/http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/immigration-asylum-research/immigration-q4-2011/>

<sup>4</sup> “Psychological distress amongst immigration detainees: A cross sectional questionnaire study”, *British Journal of Clinical Psychology* 2009, Katy Robjant, Ian Robbins and Victoria Senior, p.276.

<sup>5</sup> Report of Professor Cornelius Katona, Consultant Psychiatrist, 7 October 2013, para 3.1.5, p.6.

<sup>6</sup> “Mental health implications of detaining asylum seekers: systematic review”, *British Journal of Psychiatry* 2009, Katy Robjant, Rita Hassan and Cornelius Katona, p.308.

<sup>7</sup> “Impact of immigration detention and temporary protection on the mental health of refugees”, *British Journal of Psychiatry* 2006, Zachary Steel, Derrick Silove et al, p.61-63.

<sup>8</sup> RCPsych 2013 position statement on detention of people with mental disorders in Immigration Removal Centres (copy attached), but also on [www.rcpsych.ac.uk/pdf/policyandparliamentary/projects/live/asylumseekers.aspx](http://www.rcpsych.ac.uk/pdf/policyandparliamentary/projects/live/asylumseekers.aspx)

7. The Independent Monitoring Boards for IRCs have also commented on the detrimental impact of lengthy detention on detainees' mental health:

“[t]here is a minority of detainees within the Immigration Detention Estate who are being held for excessive indeterminate periods, and this has a detrimental affect on their mental health.”<sup>9</sup> (*sic*)

8. The situation is further exacerbated by failed removals which, as highlighted by the IMB in its 2012 Annual Report for Yarl's Wood, have a huge impact on detainees' anxieties and state of mind.<sup>10</sup>
9. One advantage which the prison system has over the detention centre system is that sentences in prison are structured and transparent in that they contain a custodial period, with a review in advance of the conclusion of that period, and (usually annual) reviews thereafter. Those reviews are conducted by the Parole Board - an independent judicial body - and are assisted by multi-disciplinary reports. There are also, alongside, matters such as security categorisation reviews. The result is a system that is understood by prisoners, and by all those with whom they come into contact, and a system in which regular independent review is a long-established feature.
10. There is no equivalent in long-term immigration detention. Equally, and as already indicated, the periods of immigration detention have been rising in recent years, sometimes as a result of the actions of third party States over which neither the detainee nor the UK have any control. The result can be bewilderment on the part of detainees, who simply do not understand what is happening to them, and who cannot obtain meaningful information from the staff around them (who may well not have relevant information, particularly if the problem lies with the relevant embassy). Such problems are of course exacerbated where a detainee has mental health problems.
11. Mental health care in immigration detention is often woefully inadequate. Reports from independent monitoring bodies such as the HM Inspectorate of Prisons (HMIP), have consistently and routinely found profound failures in the care of the mentally ill detainees in immigration removal centres. By way of example only, in 2009 HMIP described its report on Tinsley House IRC as “deeply depressing”. It found that there was no regular input from community mental health teams and there was a lack of active nursing input for detainees with severe mental health needs, giving the following example:

“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.”

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<sup>9</sup> *Colnbrook Immigration Removal Centre Annual Report 2012*, Independent Monitoring Board, p.14. Available at: <http://www.justice.gov.uk/downloads/publications/corporate-reports/imb/annual-reports-2012/colnbrook-irc-2012.pdf>

<sup>10</sup> *Supra*, note 1, at 19.

12. In 2010 HMIP described Brook House IRC as follows:  
 “[W]e were disturbed to find one of the least safe immigration detention facilities we have inspected, with deeply frustrated detainees and demoralised staff, some of whom lacked the necessary confidence to manage those in their care. At the time of the inspection, Brook House was an unsafe place.”
13. In 2011 the HMIP inspection of Harmondsworth IRC identified the following concerns, among many others:  
 “A major area for on-going concern was health care, which remained a source of considerable complaint from detainees. Mental health needs were under identified and the inpatients department was described by staff themselves as a ‘forgotten world’. The poor service we witnessed the last time we visited was still evident in many respects [...]”
14. In the last two years the High Court has found five breaches of the absolute prohibition of inhuman and degrading treatment in Article 3 of the European Convention on Human Rights arising out of the treatment of mentally ill detainees in immigration detention: *R (S) v Secretary of State for the Home Department* [2011] EWHC 2120; *R (BA) v Secretary of State for the Home Department* [2011] EWHC 2748; *R (D) v Secretary of State for the Home Department* [2012] EWHC 2501; *R (HA (Nigeria)) v Secretary of State for the Home Department* [2012] EWHC 979; *R (S) v Secretary of State for the Home Department* [2014] EWHC 50 (Admin). This is unprecedented and stands as a salutary statement that the UK is continuing to abuse the rights of the mentally ill in detention.
15. The gravity of these findings has been identified by the Home Affairs Select Committee’s report *The Work of the UK Border Agency* (April – June 2012) HC 603, where it stated at [15]: ‘[w]e 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’, and in *The effectiveness and impact of immigration casework* December 2012, a joint inspection report by HMIP and the Independent Inspector of Borders and Immigration, where it is stated in the introduction that ‘[t]here was little evidence of the effectiveness of Detention Centre Rule 35 procedures, which are supposed to provide safeguards for vulnerable detainees, including those who have mental illnesses.’
16. It is in this context that MHIDWG responds to this consultation and it urges the Home Office to have regard to the extreme vulnerability of immigration detainees, the fundamental right to liberty under our common law and the need to put an end to the serious abuses of human rights that take place at the hands of public authorities like the UK Border Agency (as it was) when considering how to assess and formulate policy in this area.

#### The background to this consultation

17. In *R (HA (Nigeria)) v Secretary of State for the Home Department* [2012] EWHC 979, Singh J held that the Secretary of State’s policy of detaining people with mental health problems breached the obligations under the Race Relations Act 1976. During the hearing of that case the Secretary of State gave an undertaking to the Court that she would carry out an equality impact assessment of the policy forthwith. That was in March 2012, two years ago. Since that time the Secretary of State has been operating a policy that has not been assessed for its impact on people from BME groups or disabled people. While it is welcome that some effort

is now being made to conduct that assessment, MHIDWG is deeply dismayed that it has taken this long, and that this consultation is not a public one capable of eliciting the views of those affected by it.

### This consultation

18. As set out above, we understand this consultation to be part of the Secretary of State's response to the findings in *R (HA (Nigeria)) v SSHD* in which the court held that she had failed to comply with what was then known as the race equality duty. This has been replaced by the public sector equality duty ("PSED") as set out in s.149 Equality Act 2010 which reads as follows:

"Public sector equality duty

(1) A public authority must, in the exercise of its functions, have due regard to the need to—

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.<sup>2</sup>

19. Further subsections of s.149 elaborate on how public bodies should meet this duty, particularly in relation to disability equality and the requirement to have due regard to the need to advance equality of opportunity. Given the basis on which this consultation is being undertaken, i.e. to meet the concerns of the court in *HA (Nigeria)* in respect of the (then) race equality duty, we are concerned at the lack of any, or any adequate, reference to the content of s.149 so as to allow consultees to provide the SSHD with the necessary information so that she can meet the PSED. The focus of the three distinct limbs of s.149 is on specific statutory needs that must be met; it is not sufficient to refer generally to "equality issues" as the consultation document does in its questions, nor is it sufficient to ask for evidence of discrimination. The PSED goes further than this: it is a positive duty on the SSHD to gather the necessary information and evidence; to have due regard to the statutory needs; to identify any adverse impact on those with protected characteristics and to consider any appropriate mitigation or changes to the proposed policy.

20. In addition, it is well-established that the public authority, in meeting its duty, must undertake sufficient enquiry to have due regard: it must ask itself the right questions. Guidance from the EHRC confirms that this may need to include engagement with the service-users affected by the policy under review. We are therefore concerned at the limited number of consultees and the lack of any attempt to engage with detainees or ex-detainees as far as we are aware. Whilst there is no legal obligation on the SSHD to carry out an EIA, having agreed to do so, this process should be open and transparent, and arguably should be made public. If the SSHD does not have the right information and evidence from the right sources as to the impact of her policy on race and disability equality, she will not be in a position to have "due regard" and comply with s.149 EA 2010.

21. We have raised our serious concerns about this consultation with the Home Office directly. We alerted the Home Office to the fact that some of the named consultees had not received copies of the consultation document, that the target list did not include anyone from the target populations and that other key interested parties, including the Royal College of GPs and the Royal College of Nursing, were not including on the initial list. As a result of these flaws, we requested a 28 days extension and the addition of more consultees to the list. Neither of these requests were granted.

### Response

22. At the outset MHIDWG emphasises its strong position that detention is bad for mental health. It tends to make existing conditions worse and to cause mental illness in those who have previously been mentally well. It is our view that the mentally ill are not only over-represented in detention, but that the presumption that operates on the ground is that people should be detained, very frequently without any consideration to what the effect is on their mental health. This has led to the egregious human rights abuses cited above and calls for a fundamental shift in the attitude to mental health and detention. It is hoped that a reformulated policy will reflect such a shift.
23. In this response we refer in particular to the position of the Royal College of Psychiatrists on immigration detention and mental health and to the report of Dr Kamaldeep Bhui, originally prepared for Mind's intervention in the case of *R (Das) v Secretary of State for the Home Department* [2014] EWCA Civ 45. These documents are appended for ease of reference.
- *How should the balance be struck between individual interests and collective interests in upholding UK law and immigration policy in relation to those with mental health issues? Should that balance take account of individual circumstances or prescribe a general approach that does not require individual consideration (for example, a complete prohibition of detention of any person with significant mental health issues in any circumstances; or identification of particular mental health conditions that will always preclude detention)?*

MHIDWG does not consider that the balance between individual interests and collective interests should take account of either individual circumstances or prescribe a general approach. It is our view that both are necessary in order to achieve a policy that can be understood properly and operated lawfully. What must be considered is the nature and extent of a person's mental illness and the impact that detention has on a person's mental health. This is not to say that general principles and guidance cannot be provided. We consider the previous policy which provided that people with a serious mental illness should not be detained except in very exceptional circumstances represented an approach which was lawful and provided greater protection for both individual and collective interests.

24. The question uses the phrase "significant mental health issues". The policy uses the word "serious" not "significant". In MHIDWG's view the word serious is appropriate in this context. In a report prepared for Mind and Medical Justice's intervention in the case of *R (Das) v Secretary of State for the Home Department* [2014] EWCA Civ 45, Dr Kamaldeep Bhui, Professor of Cultural Psychiatry and Epidemiology and Honorary Consultant Psychiatrist based at Barts & The London

School of Medicine and Dentistry and East London Foundation Trust, gave the following guidance on the meaning of “serious” in this context:

“Previously, the term ‘serious mental illness’ was applied to individuals with psychoses, such as schizophrenia or bipolar affective disorder, reflecting more their inability to function or the level of disability they experience. However, people with anxiety or panic disorder may also be disabled but these are often, not rightly in my view, seen as less serious. Many people with schizophrenia or bipolar disorder would be able to function well in the community. ‘Serious’, therefore, should be used to reflect the symptom profile and associated level of functioning or disability experienced by an individual rather than the diagnostic category or service setting.” [Emphasis added]

25. The Royal College of Psychiatrists “Position Statement on the detention of people with mental disorders in Immigration Removal Centres”, provides the following definition of a serious mental illness at p.6:

“As the Royal College of Psychiatrists, we would like to define ‘person suffering from serious mental illness’ as a person with active symptoms and impaired social functioning as a result of their mental disorder”

26. In order that caseworkers understand the threshold of seriousness it is suggested that guidance is provided in the policy that reflects these definitions and ensures that an unduly restrictive approach to the seriousness threshold is avoided.
27. MHIDWG does not agree that any revised policy should give an exhaustive list of mental health conditions that will always preclude detention (in this regard see the judgment of the Court of Appeal in *Das* at [57] where it was stated, “diagnosis is not in itself the key to the applicability of the policy”). There are conditions for which detention is contra-indicated, such as PTSD. However, any mental health condition may be aggravated by the experience of detention and it should be the nature and severity of the illness and the impact of detention, not the categorisation of the condition, which determines whether detention can be justified.
28. Furthermore, any attempt to give a list of mental health conditions will inevitably run into problems of definition and diagnosis which will render the policy too uncertain to be applied consistently and predictably: the question of what constitutes a serious mental illness is not straightforward and will vary from case to case. There are a range of relevant indicators, but MHIDWG does not consider it would be helpful, nor indeed accurate, for the meaning of this phrase to be dictated by an exhaustive or prescriptive list of criteria for the following reasons:
- i. A strict definition risks excluding people whose mental health fluctuates or who have experienced mental health problems in the past, are currently well, but whose mental health is likely to be detrimentally affected by detention.
  - ii. A definition which relies on an individual being medicated would not be appropriate, as many people’s mental health problems are managed without medication, for example by counselling and other support services.
  - iii. A definition which relies on an individual having a formal diagnosis risks excluding the many individuals who experience mental health problems which are never diagnosed, sometimes because they have not sought assistance from health services.

- *What specific equality issues arise from a situation where persons suffering from mental illness may be detained? Do those issues vary according to the nature and seriousness of the mental health issues and the ability of treatment or management to mitigate any adverse effects?*
29. The main equality issue which arises when a person suffering from mental illness is detained is that the very fact of detention will have a specific adverse impact on him or her which is different from the impact on a person without that protected characteristic. The fact of the detention may exacerbate or cause permanent harm to an existing condition. The equality issues that arise when a person is detained touch on a number of protected characteristics that will be shared by many, if not most, detainees. The first protected characteristic is that of race. In this regard it is vital for any policy to recognise the culturally specific needs of the detained population. This includes providing services in different languages but also providing services sensitive to the particular issues that arise for this group, including the type of treatment that they may have suffered in their home country, any perceived stigma around mental illness, fear or mistrust in authority figures and the role of cultural practice, religion and belief.
  30. The second key protected characteristic is that of disability, which all detainees with mental health problems share. All of the examples and issues raised in this response are directed to demonstrating and commenting on the equality issues that arise when disabled people are detained.
  31. A person with mental health needs may also be disabled within the Act for other reasons, eg long term physical health needs such as HIV or a physical disability which may intensify the adverse impact of detention, and complicate care needs.
  32. The issues that arise when a person is suffering from a mental illness in immigration detention will inevitably vary according to the nature and severity of that illness and the availability of effective treatment. In this regard the definition of “satisfactory management” of mental illness is particularly important. MHIDWG’s strong view is that guidance needs to be provided to case workers on the meaning of satisfactory management and that this guidance needs to concur with best medical practice.
  33. It is MHIDWG’s view, drawing on what is understood and accepted about best practice and clinical guidance, that a mental health problem is not satisfactorily managed if it could be improved, through treatment or otherwise, but is not being so improved. This will be the case whatever the protected characteristics of the detainee or the nature of their mental illness. This is because, in a clinical context, “management” refers to the totality of the processes involved in providing care and enabling treatment to take place so as to promote maximum functioning and recovery where possible. It implies the correct diagnosis of a mental health problem and an understanding of how it should be treated. It follows that it cannot be suggested that serious mental health problems may be satisfactorily managed in an IRC if they are not worsening.
  34. MHIDWG considers that where something can be done to prevent deterioration, promote recovery and alleviate suffering, it should be done, which may mean (for those people for whom hospitalisation is not the most clinically appropriate option) releasing them into the community unless very exceptional circumstances make this impossible. As the Court of Appeal recently reminded us in *Das*, “the mere liability to be removed and refusal to leave voluntarily cannot constitute the “very exceptional circumstances” required or the policy would be denuded of

virtually all its operation” (the Court gave the example of a person who poses a risk of killing someone as a very exceptional circumstances). This view is supported by Dr Bhui:

“If a mental health problem or symptoms of mental illness could be alleviated by treatment then they should be; unless the individual specifically requests that they prefer the existence of symptoms rather than the existence of adverse effect brought on by pharmacological treatments ... Satisfactory management ... should include the prevention of deterioration as well as the alleviation of existing symptoms to enable optimal functioning in the least restricted environment possible for the purposes of treatment.”

35. It is the view of the Royal College of Psychiatrists that a therapeutic intervention plan can only be considered as satisfactory management of mental disorder if it incorporates:

“biological, psychological (including psychodynamic) and social components. Such a plan should also aim to minimize any biological, psychological or social factors that contribute to the maintenance or worsening of the individual’s mental illness. Biological treatments include psychotropic medications, management of associated physical conditions, monitoring of mental state and side effects and specialist treatments like electro convulsive therapy etc. Psychological treatments include supporting counselling, various forms of cognitive and behavioural therapies, specialist psychological interventions, psychotherapies etc. Social interventions include ensuring an appropriate social and living environment, ensuring social support including that from family, promoting a social network, and developing community rehabilitation pathways with the help of occupational therapy.”

36. If these treatments are not available or not effective in an IRC setting, the detainee should be released into the community.

37. In summary, in MHIDWG’s opinion a person’s mental health will not be satisfactorily managed in detention if:

- The experience of detention causes or exacerbates mental health problems;
- The person is susceptible to acute or crisis episodes of mental illness which a detention centre does not have the facilities or staff to deal with appropriately;
- The person’s mental health could be improved if treated in the community; or
- The person’s mental health could be improved by a particular treatment, such as counselling, but that treatment is not available in detention, or it is not available without delay.

38. In our view, if the concept of satisfactory management is not interpreted to include the promotion of improvement or recovery, it will fall below the standards that govern mental health care in the community and in hospital. That must be avoided: immigration detainees are entitled to the same level of support and treatment in detention as they would receive outside.

39. It is also MHIDWG’s view that independent clinical input is required in order to determine whether someone’s mental health problem can be, or is being, satisfactorily managed in detention. One way of doing this would be to model the

system on the safeguards used under the Mental Health Act 1983, whereby two clinically qualified staff (for example, an approved mental health practitioner and a registered mental health nurse) would have to attest to whether a person's mental illness could be satisfactorily managed in detention and, if a person is detained, would conduct regular assessments of whether it is in fact being satisfactorily managed.

40. However, given the negative effects of detention in most cases<sup>11</sup>, we believe the existence of mental illness in itself should raise a strong presumption against detention.

41. Specific issues will also arise in relation to detainees who lack mental capacity to make decisions for themselves. These cases raise particularly complex issues that are not addressed in the current policy and put this group at a serious disadvantage as a result of their disability. By definition, people who lack capacity are extremely vulnerable. There is no mechanism in IRCs for such people to be independently represented. This is in stark contrast to the position of people who lack capacity and are detained in hospitals or care homes. In these settings people who lack capacity have a right to an Independent Mental Capacity Advocate who can ascertain their wishes as far as is possible and ensure that actions are taken in their best interests. It is MHIDWG's view that the same or a similar mechanism must be established in IRCs so as to ensure that this group are not discriminated against and have their rights protected. This is especially important given the overwhelming importance of some of the decisions required of detainees (e.g. whether to claim asylum; whether to seek legal advice and representation in relation to their immigration case or to challenge their continued detention; etc).

- *What specific equality issues arise from the policy as formulated at present?*

42. As stated above, the policy, as it is currently formulated and operated, does not comply with the equality duties. The impact of detention on people with disabilities is disproportionately adverse and unjustifiable. The lack of culturally specific and sensitive services in detention aggravates this disadvantage in many cases. As explained above, the very fact of detention has an adverse impact on people with mental health needs. There is therefore a need for a robust decision making process at the point of detention to ensure that such needs are identified.

- *Do you have any evidence that you believe shows that detaining such persons will have a disproportionate impact on any of the equality groups that you think should be considered in assessing the equality impact?*

43. Yes. As stated above, there have been five recent cases finding a violation of prohibition of inhuman and degrading treatment arising out of the detention of mentally ill people. These are the cases that get to court. As practitioners in this area, we know of many more cases that settle in the detainee's favour before they are litigated and which disclose varying degrees of ill-treatment of mentally ill detainees.

44. The most recent case of S provides a summary of the failings that disproportionately impact on people with mental health problems at [336]:

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<sup>11</sup> The Royal College of Psychiatrists believes 'that detention centres are likely to precipitate a significant deterioration of mental health in the majority of cases, greatly increasing both the suffering of the individual and the risk of suicide and self-harm'.

- (1) The inadequate standards of care provided for immigration detainees, particularly in relation to mental health healthcare.
- (2) The inadequate, uncoordinated and disparate sets of documentation maintained by the UKBA and Healthcare Centres about an individual detainee which are neither fully logged in a central logging system nor maintained centrally in legible and accessible form.
- (3) The inadequate disclosure of material internal UKBA detention and treatment documentation and the SSHD's reliance in fulfilment of its discovery obligations on redacted documentation previously disclosed to the claimant or the retained solicitor in a subject access requests made by or on behalf of the detained claimant.
- (4) The failure to transcribe relevant but illegible manuscript notes and records into legible word processed documents.
- (5) The lack of a chronological consolidated bundle of all documents indexed and paginated with a list and description of all those involved in the making of those documents or who are referred to in them.
- (6) An explanation of acronyms and an organisation chart showing the relationship between individual immigration officers and between different parts of the UKBA involved with the claimant detainee.
- (7) A lack of evidence provided by the SSHD from witnesses, including evidence from those involved with, and with a first-hand knowledge of, the claimant detainee's assessment, monitoring, treatment and observation whilst in immigration detention and of the basis of individual detention and maintaining detention decisions.
- (8) Disclosure of the relevant documents that identified the contracted standards and levels of treatment applicable to the claimant, the numbers being treated in the relevant Healthcare Centre, staffing levels and publicly accessible information such as Healthcare monitoring reports about any relevant shortcomings in the particular Healthcare Centre or Centres involved.
- (9) Disclosure of information that identified the training and working conditions that the operator of, and the individual members working within relevant healthcare centres received and should receive.
- (10) An explanation of the recording obligations in relation to and the records maintained about the health of and the healthcare and medication provided to the detained claimant.
- (11) A summary of the relevant training, instructions and guidance given to relevant immigration officers and healthcare members including any training and guidance about mental illness and disability, equality and other relevant human rights issues relevant to the detention and its maintenance of those suffering or apparently suffering from mental illness or mental disability.
- (12) A summary of the relevant parts of any relevant protocols or practice concerning the assessment, treatment and healthcare record-keeping of mentally ill immigration detainees. Also, the law and practice pertaining to information access and sharing of health and treatment records of mentally ill detainees between decision-makers and healthcare services within the NHS, between individual healthcare centres, individual decision-makers of decisions taken about immigration detention and the population movement of such detainees and between the SSHD and UKBA and the detained claimant and his or her legal advisers.

45. Furthermore, as stated above, the particular characteristics of immigration detainees, and asylum seeking detainees in particular, are such that they may be much more vulnerable to the deleterious effects of detention, particularly long-term or indefinite detention.

- *Do you have evidence that the detention of such persons discriminates against particular equality groups?*
46. Yes. As stated above, detention has a particular adverse effect on people with mental health problems, which may be aggravated for people from BME backgrounds because of the unavailability of adequate and effective treatment in general, and culturally sensitive and appropriate treatment in particular. It also has an adverse impact on women with mental health needs and one those with other forms of disabilities or chronic health needs who would fall within the definition of 'disabled'.
- *Are there any other sources of data that would give an accurate picture of how detention of those with serious mental health issues could impact on equality groups?*
47. The report from the MHIDWG (appended) lists and comments upon the then readily-available sources of data<sup>12</sup>. When healthcare in IRCs falls under the NHS, systems for recording routine clinical information will improve and in time enable audits of those accessing healthcare. In addition, it is our view that the Home Office should read all the HMIP inspection reports of IRCs and the IMB reports of the same. The other key source of data is from detained people and people with mental health problems. As far as we are aware no effort has been made to seek the views or understand the experiences of these people because the consultation is not public and because it has been conducted in too short a time frame for representative bodies like Medical Justice to seek the views of detainees. This fundamentally undermines any suggestion that the Home Office has sought sufficient data to conduct an adequate assessment of how the detention of people with serious mental health problems impacts on equality groups.
- *Is there a formulation of policy in this area that better accommodates the relevant individual and collective interests taking account of equality considerations?*
48. Given the negative effect of detention on the majority of people with mental health problems and the widespread failings in ensuring that detainee's mental health needs are identified, assessed and documented by IRC healthcare staff and appropriately taken into account by home office caseworkers, we believe that a general strong presumption against detaining the mentally ill, without a 'satisfactory managed' requirement, comes closer to compliance with these interests and with equality legislation.
- *Do you have any suggestions of how such equality issues could be addressed or mitigated under the existing policy or any reformulated policy specified?*
49. See the proposals put forward in response to other questions.
- *Are there particular facilities or services that should always be available to all detainees in immigration removal centres in connection with mental health issues? If so, what are they?*

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<sup>12</sup> Mental Health in Immigration Detention Action Group Initial report Dec 2013 on [www.medicaljustice.org.uk](http://www.medicaljustice.org.uk)

50. Immigration detainees are entitled to the same health care that would be available in the community. Furthermore, these services must be tailored to meet the specific needs of this group, including needs arising from all of the protected characteristics under the Equality Act 2010. Moreover, for such time as the Home Office continues to lead on healthcare in detention, that department must urgently address how it is to give effect to the recommendations and findings of the Royal College of Psychiatrists' March 2013 report on 'achieving parity between mental and physical health' following the request of the Care Minister that the President of the College lead an expert working group into the concept of parity of esteem and how to give this effect.<sup>13</sup>

There are also additional healthcare requirements arising from the fact of being in detention, which differ from those in the community, in particular an initial and ongoing mental assessment needs to be available to establish the impact of detention and advise Home Office officials of adverse impacts to inform decision-making.

At present many detention centres fail to meet the most basic requirements, eg sufficient regular visits from a psychiatrist. In the S decision referred to above, there was a 6 week gap between psychiatric appointments for an acutely psychotic detainee.

51. Dr Bhui summarises the basic requirements of mental health care as follows:

“ensuring that available interventions, which were evidence-based and wherever possible supported by NICE guidelines, are made available in the earliest possible fashion to act to remedy existing symptoms of mental illness as well as prevent deterioration, or exacerbation of existing symptoms, or more severe mental illness emerging.”

52. MHIDWG endorses this view. Mental health care in the community involves a range of treatments that are not limited to, and may not include, medication. The same range and quality of treatments must be available to immigration detainees. It is important to remember that the fact that medication is being prescribed does not mean that treatment is adequate or that a mental health problem is being satisfactorily managed. Furthermore, where medication is prescribed, detainees should be given information about its risks and possible side effects and assurance sought that medication is indeed dispensed and taken: this did not happen for 'S' for example.

53. Mental health care in detention should therefore include the provision of talking therapies such as counselling, cognitive behavioural therapy, access to therapeutic groups and activities, drop-in sessions, specialist services and alternative therapies, all delivered by competent practitioners and consistent with NICE guidance. The Royal College of Psychiatrists considers that the provision of such wide-ranging interventions would be difficult to achieve in a detention setting, particularly in relation to conditions such as PTSD:

“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. However for some patients working through their trauma directly in focussed psychological treatment may

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<sup>13</sup> see <http://www.rcpsych.ac.uk/files/pdfversion/OP88xx.pdf>

be too upsetting emotionally and not possible initially. They benefit from a supportive therapeutic relationship in which they can work toward longer term external goals such as building relationships, engaging in social activities and developing educational and occupational skills. A community context is key in this, as is an atmosphere in which they can increasingly focus on their future and stop thinking about the past. This would be hard to achieve in a detention situation where the very fact of detention and the imminent risk of return is a constant preoccupation keeping their fears and symptoms constantly alive.”

54. In accordance with the Mental Health Act 1983 Code of Practice and the NICE Clinical Guidance, detainees should be provided with comprehensive information about the available treatment options in a language and format that they understand.
55. Detainees’ access to treatments should be timely, in accordance with the time scales adhered to in community mental health care.
56. Importantly, it is MHIDWG’s view that where community-based treatment is recommended by a clinician, a detainee should be released unless there is a very good reason for continuing detention.
57. MHIDWG is aware that in some cases the Home Office has suggested that it is not appropriate to release a mentally ill detainee because they will not have adequate accommodation in the community (indeed there have been several cases where the Home Office has sought to justify detention on the basis that it is an individual’s best interests given the lack of accommodation in the community). Such an approach cannot, in MHIDWG’s view, be right or lawful. Quite apart from what the arguments about the risk that such a basis for detention amounts to detention for an improper purpose<sup>14</sup>, any “best interests” determination would have to comply with the requirements of the Mental Capacity Act 2005, or (in the case of an adult with mental capacity), the individual him or herself.
58. In any event, there are many routes to accommodation: mentally ill detainees may be provided with accommodation under section 21 of the National Assistance Act 1948 or section 4 of the Immigration and Asylum Act 1999. Alternatively mentally ill detainees may be admitted to hospital informally if they are in need of in-patient treatment for their mental health problems.
59. As stated above, it is also MHIDWG’s view that Independent Mental Capacity Advocates should also be provided to detainees who lack, or may lack, capacity.
  - *Are there ways in which the provision of facilities or services to detained persons with mental health issues could be improved? If so, what action is required by the relevant providers (including the Department of Health)? How do those facilities and services compare to what would be available in the community?*
60. There are many ways in which the treatment of mentally ill detainees could and should be improved. In this regard we refer back to paragraph 40 above on the numerous failings found by the High Court in a recent case.

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<sup>14</sup> See for example *R(AA) v SSHD* [2010] EWHC 2265 (Admin) at [40]

61. In addition, it is MHIDWG's view that there are grave risks in any Home Office policy on mental illness being operated by non-clinically trained immigration staff. All immigration caseworkers should undergo compulsory mental health awareness and mental health first aid training. Without this training it is inevitable that staff will be unable to identify those detainees who were developing a mental health problem or whose existing mental health problem was deteriorating. This is so even where they are consulting healthcare staff at the IRC (for the purposes of securing a Rule 35 report): without the proper training, caseworkers may not be able to ask the right questions, or be able properly to assess the answers they are receiving. Our understanding is that at the moment, caseworkers tend to restrict themselves to asking an "are they fit to be detained" question, but even then appear to disregard many opinions from IRC doctors. That, like the question of "satisfactory management", begs very many more questions.
62. Home Office staff and IRC (including initial accommodation) Healthcare Teams should receive training in identifying mental distress. They should have a clear understanding of why someone may not disclose mental health problems at screening or within initial accommodation, and have the skills to recognise indicators of mental ill-health and respond appropriately.
63. Staff should also undergo compulsory training on the provision of culturally appropriate mental health care. Following the NHS/NICE Clinical Guidance, this should include the ability to be sensitive and respectful of detainees' cultural, ethnic and religious backgrounds and to be aware of possible variations in the presentation of mental health problems in detainees from different backgrounds.
64. IRC healthcare staff should receive specific training on assessing and reporting on the effect of detention on a detainee's mental health in such a way that home office staff are able to understand whether a detainee's health could be improved, deterioration prevented or suffering alleviated by receiving treatment in the community.
65. Staff should also receive training on the difference between the Mental Health Act 1983 and the Mental Capacity Act 2005 so that they understand how the two statutory regimes relate to each other and can recognise a situation where a detainee's capacity needs to be assessed.
66. Staff should be trained in confidentiality so as to ensure that detainees' confidentiality and privacy rights are respected.
67. Given the failures identified in care, there needs to be a system of monitoring and reviewing the care provided, targets for improvements and sanctions for providers who fail to comply with basic requirements such as proper record-keeping and recording of medicines administered.
68. MHIDWG is also concerned about the ongoing use of disciplinary sanctions (particularly under Rules 40 and 42) to deal with people who present challenging behaviour as a result of their mental health problems. In MHIDWG view, policies must be developed to ensure that challenging behaviour is dealt with in the least restrictive and most therapeutic way possible. This means that staff must be trained in using de-escalation techniques and care plans should be developed with detainees to plan responses to their behaviour if it becomes challenging. The correct approach to control techniques is laid out in the Code of Practice to the Mental Health Act 1983 and IRCs should apply the same principles.

69. In addition, it is important for staff to recognise when the reason that someone is exhibiting challenging behaviour is because they are unwell rather than being disruptive. IRCs must develop appropriate facilities for detainees who present challenging behaviour as a result of their mental health problems. It is not appropriate for mentally ill detainees to be housed in areas designed for punishment or with detainees who are subject to disciplinary sanctions.
70. If segregation is used, it is MHIDWG view that the Home Office should implement the HMIP's recommendation that an initial health screen be carried out prior to segregation and that multi-disciplinary reviews of segregation take place as they do in the prison context.

**21 March 2014**  
**Mental Health in Detention Action Group**

## **Appendices**

**Appendix A** - The Royal College of Psychiatrists: Position Statement on detention of people with mental disorders in Immigration Removal Centres.

**Appendix B** – Prof Kamadeep Bhui: Statement in support of Mind's intervention in the case of *Das v Secretary of State for the Home Department*.

**Appendix C** – Mental Health in Immigration Detention Action Group: Initial Report.