The Royal College of Psychiatrists

Position Statement on detention of people with mental disorders in Immigration Removal Centres

Background

In August 2010, the UKBA changed the wording of the policy on detaining people with mental health problems. Under the heading 'person considered unsuitable for detention', the previous policy provided that the mentally ill would 'normally be considered suitable for detention in only very exceptional circumstances' (enforcement instruction and guidance (EIG), chapter 55.10, version 9). The exclusion was amended to state: 'those suffering from serious mental illness which cannot be satisfactorily managed within detention' (version 10)[1]. This amendment effectively reversed the presumption against detaining mentally ill people. The secretary of state did not consult on this change of wording, nor did she undertake an equality impact assessment (EIA).

Over the last two years, the High Court has found breaches of the absolute prohibition of inhuman and degrading treatment in Article 3 of the European Convention on Human Rights in four immigration detention cases, in relation to the ill treatment of detainees with mental illness[2]. In R (HA (Nigeria)) v Secretary of State, the secretary of state's policy of detaining or continuing to detain mentally ill people was declared unlawful[3].

The secretary of state had failed adequately to address HA's disturbed behaviour (the response from IRC staff had been to segregate HA and use force against him) and secure HA's transfer to hospital to meet his urgent need for assessment and treatment.

The judge desisted from quashing the unlawful policy in the light of the Home Secretary's formal undertaking that she would begin to carry out an EIA of the policy. She was granted permission to appeal to the court of appeal and no EIA was conducted[4]. The Secretary of State eventually decided not to appeal. Despite this no EIA has yet been carried out.

In R (Das) v Secretary of State the claimant challenged her detention[5]. The court found that the Home Secretary had failed, in breach of her public law duty of inquiry, to consider available

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1 This UK border agency manual contains guidance and information for officers dealing with enforcement immigration matters within the United Kingdom. Chapter 55.10 deals with person considered unsuitable for detention. It lists 'those suffering from serious mental illness which cannot be satisfactorily managed within detention. In exceptional cases it may be necessary for detention at a removal centre or prison to continue while individuals are being or waiting to be assessed or waiting transfer under the Mental Health Act. (http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/enforcement/detentionandremovals/chapter55.pdf?view=Binary)

2 R (S) v Secretary of State for the Home Department [2011] EWHC 2120 (Admin), 5 August 2011; R (BA) v Secretary of State for the Home Department [2011] EWHC 2748 (Admin), 26 October 2011; R (HA (Nigeria)) v Secretary of State for the Home Department [2012] EWHC 979 (Admin), 17 April 2012; R (Das) v Secretary of State for the Home Department [2013] EWHC 682 (Admin), 26 March 2013.

3 HA was Nigerian man with serious mental health problems who was detained under immigration powers for two periods in 2010. During the first five months period of detention, his mental health deteriorated to such as extent that he needed admission to the hospital under the MHA. Following his time in the hospital, he was returned to immigration detention centre for a further two months.

4 Spurrier M and Willman S, 'Mental health and immigration detention post-HA', Legal Action law & practice/mental health, July/August 2013, p32.

5 The claimant arrived in UK in 2004 with a leave to remain as an overseas domestic worker, which was renewed from time to time. The claimant later made accusations against her employers that they treated her very badly, including assaulting her. The claimant left the employment in 2008 and presented herself to relevant UK authorities.

medical evidence concerning the claimant's mental health. Detention was accordingly unlawful. However, the claimant was only granted nominal damages since according to the ruling at no time was she entitled to release under the home secretary's policy (Chapter 55.10 of the Enforcement Instructions and guidance)because she did not suffer from 'serious mental illness' and it had not been demonstrated that her illness could not be 'satisfactorily managed in detention'.

Both the amendment in the policy and the Judge's guidance in R (Das) v Secretary of State for Home Department on defining what constituted serious mental illness have raised issues regarding the definition of 'serious mental illness' and of what constitutes 'satisfactory management of mental illness'.

For the Royal College of Psychiatrists, the two key questions that require consideration are:

- Under what circumstances (if any) does the presence of a mental disorder make it inappropriate for a person with a mental illness to be subjected to administrative immigration detention?
- Can any mental disorders can be satisfactorily managed in the immigration detention setting?

Mental disorders among asylum seekers and people in detention centres

When considering any policy on managing mental illness, it is important not to restrict to just the management of mental illness but to consider a broader concept of mental disorder that would also include people with intellectual disabilities and people with neuro-developmental conditions like autism etc. The Mental Health Act (2007)[6] also allows such a broader categorization which recognizes the mental health related needs of this population.

In 2011-12, the number of immigration detainees rose by 14%. Research suggests that a high proportion of immigration detainees displayed clinically significant levels of depression, Post Traumatic Stress Disorder (PTSD), and anxiety, as well as intense fear, sleep disturbances, profound hopelessness, self-harm, and suicidal ideation. A systematic review of the literature by Robjant et al also reported high prevalence of mental disorders and use of psychotropic medications among detainees[7]. Experience also suggests that conditions seen in these detention centres were complex and difficult to treat. Conditions like PTSD are difficult to treat and are often unresponsive to medication only treatment thus requiring expert interventions or specialist therapeutic input which is not available in the detention setting.

Clinically, it is unsurprising that the prevalence of mental illness is high in immigration detainees, who are likely to have experienced stressful life events that probably acted as predisposing factor to their mental illness. These may have included detention (and associated torture) in their country of origin or during their journey to the UK, and multiple traumatic bereavements and separations. Mental health problems are therefore prevalent among asylum seekers as a whole[8][9]. Being in detention centre is likely to cause painful reminder of their past traumatic experiences and to

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Her asylum claim was rejected. Expert report on her mental health had suggested that she had suffered mental and psychological ill health as a result of mistreatment.

6 http://www.legislation.gov.uk/ukpga/2007/12/contents

7 Kathy Robjant, Rita Hassan, and Cornelius Katona, 'Mental health implications of detaining asylum seekers: systematic review', British Journal of Psychiatry, 2009, p 307

8 Note 7, p 306

9 Kathy Robjant, Ian Robbins, and Victoria Senior, 'Psychological distress amongst immigration detainees: a cross-sectional questionnaire study', British Journal of Clinical Psychology, 2009, p 284

aggravate their fears of potentially imminent return. Separation from family and social and professional support is also likely to have negative impact on their mental state. Under these circumstances, therefore, most existing mental health disorders are likely to deteriorate significantly in detention.

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

Post Traumatic Stress Disorder

PTSD symptoms are particularly likely to be aggravated by detention triggering reminders of the original trauma. This is especially the case if asylum seekers have been detained,kept in isolation, tortured and/or or deprived of their liberty as a result of trafficking or enforced domestic servitude prior to their immigration detention. In these cases the very fact of being detained, and concrete factors such as being in a cell, seeing officers in uniform, the sound of keys jangling, heavy footsteps or doors closing or being locked and unlocked will trigger intrusive memories of their previous traumatic experience - and for some reliving experiences and flashbacks when they experience past events as happening in the present. This is a significant source of suffering, and all the symptoms of PTSD including debilitating fear, insomnia, nightmares, noise sensitivity, intense agitation, autonomic nervous system hyper-arousal and dissociative symptoms are likely to worsen. So too will feelings of helplessness and depression. In this context the risk of agitated behaviour including self-harm, aggression and suicide will increase significantly as well, leading to the high rates observed in detainees.

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 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.

Depression

Many asylum seekers also have significant symptoms of depression and anxiety, which may occur independently or with PTSD symptoms as part of a complex traumatized state. Many asylum seekers have suffered multiple traumatic losses including bereavements and separation from loved ones and loss of home, status and identity in their country of origin. Such losses are well recognized as predisposing, precipitating and perpetuating factors in severe and recurrent depressive illness,

and often further compounded by the poverty and emotional isolation of asylum seekers in the UK. Unfortunately this is further compounded by uncertainty regarding asylum status, and intense disappointment with the authorities and the country to which they have turned for help. This makes it very difficult for such cases to sustain hope, leading to chronic states of helplessness and despair and increased risk of suicide.

Unfortunately, all these factors are likely to be exacerbated by detention. In particular the unpredictable event of arrest, the indefinite period of stay and chronic threat of imminent return will exacerbate helplessness in a state of intense fear. They are likely to also suffer further loss of hope or motivation, particularly in relation to hope of safety and future life goals associated with staying in the UK, further increasing the risk of suicide.

Significantly, when detained, asylum seekers also suffer loss and separation from the therapeutic and social networks they may have built in the community. This in itself would be sufficient to cause deterioration in mental state, because it constitutes a loss of therapeutic and maintaining factors which may be protecting against further deterioration and providing motivation to stay alive and recover. However, in addition, losses and separation in the present are also likely to trigger feelings associated with the losses in the past, again increasing the likelihood of deterioration and risk of self harm.

Psychosis

People with pre-existing psychoses such as schizophrenia are also likely to deteriorate due to the high expressed emotion in an environment with other frightened and angry fellow detainees. They are also at increased risk of suicide. Many asylum seekers who have PTSD also have transient psychotic experiences which are typically precipitated by stress. This may be precipitated by the stress of detention, when they may lose the capacity to distinguish flashbacks memories of persecutory events from current reality, and become acutely paranoid believing they are being pursued by persecutors in the present with associated complex visual and auditory hallucinations.

Other Mental Disorders

It is also important to consider other mental disorders, such as people with intellectual disability (ID) who may present with concurrent mental illness. Detection both of the ID and of the associated mental illnesses requires particular clinical skills. These individuals require specialist input from professionals with experience in recognition and management of mental disorders in ID, which is unlikely to be available in the immigration detention setting. People with autism spectrum disorders (ASD) are particularly likely to present with high levels of anxiety and/or agitation. This may be misunderstood as challenging behaviour, leading to a vicious circle of increasingly restrictive containment and worsening behaviour. Such individuals would benefit from structured routines and an appropriate environment tailored for their sensory needs.

Given the high risk of deterioration of mental illness in detention, and given the high risks of disturbed behaviour, self-harm and suicide associated with such deterioration, it is crucial that the clinical professionals involved, and the staff providing ongoing care, is able to identify and monitor the risks, and develop appropriate strategies and care pathways to manage this adequately.

Can mental disorder be satisfactorily managed in a detention centre?

In R (Das) v Secretary of State, the judge in his guidance on the construction of the Home Secretary's mental illness policy stated,

> "The words 'which cannot be satisfactorily managed within detention' indicate a standard of practical effectiveness of treatment, rather than treatment which avoids all risk of suffering mental ill health or deterioration in an individual's well-being. The home secretary was entitled to have regard to what may be expected in preventing a detainee from slipping into a state of serious inability to cope with ordinary life"

The estimated percentage of people self-harming in immigration removal centres during 12 months period was 12.79% compared to 5-10% for the prison community[10]. There is also growing evidence (Her Majesty's Chief Inspector of Prisons' report, HMCIP) concerning failure to identify and meet the needs of people with mental health problems in immigration detention. There was little evidence for detention centres providing specific safeguards for vulnerable detainees, such as those who have experienced torture and have mental illness. There was lack of appropriate accommodation and therapeutic day care for those who were mentally ill[11]. There are also examples where patients who have deteriorated in detention and require detention under the Mental Health Act are not appropriately transferred. This suggests that mental disorder could not be satisfactorily managed in these detention centres.

Mental health services have long since moved away from a purely medical model of mental disorder and its treatment. Clinical formulations and treatment plans generally incorporate bio-psycho-social model of mental disorder. Thus any therapeutic intervention plan that could be considered as 'satisfactory management of mental disorder' should incorporate 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. These treatments are ideally integrated by a care co-ordinator key worker working as part of a multidisciplinary Community Mental Health Team linking with social services and voluntary sector agencies. Of note, psychotropic medication in itself is very unlikely to achieve good outcomes unless given as part of a broader multi-modal therapeutic approach.

Factors known to adversely affect recovery include being in an inappropriate therapeutic environment, lack of social, family and other support networks, high expressed emotions (staff needs to be trained to understand and deal with people with high emotional needs), lack of specialist therapeutic interventions, and lack of adequate monitoring.

Responsibility for health care (including mental health care) within detention centres is in the process of being taken over by the NHS[12] (REF PICKLES AND HARTREE BMJ 2013). It is

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[10] Juliet Cohen, 'Safe in our hands? A study of suicide and self-harm in asylum seekers', Journal of Forensic and Legal Medicine, 2008, p237.

[11] http://www.justice.gov.uk/publications/inspectorate-reports/hmi-prisons/immigration-removal-centres

[12] Pickles, H. Hartree, N 'Transferring healthcare for immigration detainees in England to the NHS' British Medical Journal. 2013;346:f1884.

http://www.bmj.com/content/346/bmj.f1884?ijkey=VsFg2gfikH3VqJG&keytype=ref

strongly our opinion that the standard of health care provision should be same for detainees as is found in other NHS settings. Unfortunately this is simply not possible, for the reasons described above, for people with a mental illness in the immigration detention setting as currently constituted. The very fact of detention (which, unlike imprisonment, has no punitive or retributive function) mitigates against successful treatment of mental illness. The focus of current NHS services is on recovery from the mental disorder; such a recovery model not just treats the symptoms of the mental disorder but also focuses on community rehabilitation i.e. being able to function in society, able to care for self, able to work etc. Such a recovery model is not possible to put into action in a detention centre setting.

Detention v in-patient care

In R (Das) v Secretary of State for Home Department, the Judge decided that the home secretary had failed to consider the claimant's mental health needs. Under the home secretary's policy, Das was deemed not to be suffering from a 'serious mental illness'. While there was no qualifying definition of 'serious mental illness' in the policy, the judge gave following guidance on the construction of the Home Secretary's mental illness policy:

> "To qualify for the protection afforded by the policy, a mental condition must be such that a detainee has a serious inability to cope with ordinary life to the level, or thereabouts, of requiring in-patient treatment, or such that there is a real risk that detention could reduce the sufferer to that state"

This is extremely problematic in the context of modern mental health practice. The ethos of mental healthcare has changed over the years. The focus of the therapeutic intervention is now, wherever possible, on community based treatment rather than hospital based treatments even for people with the most serious mental health problems. There is also an accepted moral imperative (codified in both the Mental Health Act and the Capacity Act) that treatment should be provided in the least restrictive setting possible. Most people who would until recently have been admitted into psychiatric hospital for long periods were not admitted anymore or only admitted very briefly. The Mental Health Act provides options like the Community Treatment Order, which allows a community team to manage serious mental disorders in the community.

It is therefore inappropriate to define seriousness of mental illness on the basis of need for admission. Need for admission would depend more on the local model of care for people with mental disorders, resources available to treat someone in the community, availability of inpatient resources and type of inpatient resources rather than on the individual patient's clinical characteristics. More fundamentally, the clinical presumption is that admission should be avoided if at all possible. If we were to return to a policy that only people with 'serious' mental illness should not be subjected to immigration detention, this would need to incorporate a definition of what constitutes 'serious' mental illness that reflects current best practice and does not rely on equivalence to the need for hospitalisation.

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. 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.

There is a further difficulty with this ruling - the Judge's stipulation that an individual have a 'serious inability to cope with ordinary life' as a criterion for transfer to a psychiatric hospital is doubly problematic. Firstly it reiterates the use of the undefined term 'serious'. Secondly, for people already in detention, it does not take into account that their detention renders them unableunable to lead an 'ordinary life'. This makes it difficult if not impossible to determine their ability or otherwise to cope with 'ordinary life'. We also feel strongly that it is not appropriate to consider detention as an alternative or equivalent to hospital. Detention centres are not designed to be therapeutic environment. There is a particular danger of setting up a revolving door between detention and hospital.

It is also inappropriate for detainees (who are not prisoners) whose illness is so severe that they really do require hospitalisation, but who are willing to be admitted and treated to be admitted under Mental Health Act Section 47/48 provisions. This is clearly not the least restrictive option that meets their mental health care needs. Where compulsory assessment and /or treatment is necessary, the most appropriate option will normally be release from immigration detention and admission on Sections 2 or 3 of the Mental Health Act, since such hospital detention is subject to appeal and also enables appropriate discharge planning, including day leave, as well as continuity care once hospital admission is no longer necessary.

Good mental health care means providing healthcare in a least restrictive environment with avoidance of inhuman treatment. Outcomes are better when a person with a mental disorder is treated in the least restrictive environment. It is not justified to detain a person with a mental disorder for the reason of administrative immigration convenience because the severity of his/her mental illness is such that detention is more likely to have an adverse impact of their wellbeing and underlying risks.

For the same reason it is inappropriate for immigration detention to be continued or resumed because it is seen as a way of keeping a detainee safe and in contact with medical care – instead there should be appropriate planning for release and provision of appropriate community care.

The problems with planning for care on release from detention illustrate the need for a policy that takes into account the risk of deterioration into serious mental illness at the point of detention (and thereon at the earliest point this becomes apparent), so that detention of those likely to deteriorate into serious mental illness can be avoided.

Conclusions

In the recent judgement Aswat v UK[13], the ECtHR observed that both the fact of detention of a person who is ill and the lack of appropriate medical treatment may raise Article 3 issues (i.e. may constitute inhuman or degrading treatment).

There are three main elements to be considered in relation to the compatibility of an individual's health with her/his stay in detention:

[13] Aswat v UK app no 17299/12, ECtHR, 16 April 2013.

a) the individual's medical condition;

b) the impact of detention on the individual's health

c) the adequacy of the medical assistance and care provided in detention

1. In our view, people with mental disorder should only be subjected to immigration detention in very exceptional circumstances.
2. We believe 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.
3. We believe that individuals with mental disorder should receive the same optimum standard of care if they are in a detention centre as they would in any other NHS setting.
4. We feel that detention centres are not appropriate therapeutic environments to promote recovery from the mental ill health due to the nature of the environment and the lack of specialist mental health treatment resources.
5. We would like to emphasise that the current ethos of mental health services is on recovery and community rehabilitation, and this cannot be provided in a detention centre.
6. Current guidelines for good clinical practice also emphasise protecting individual rights through providing the least restrictive treatment option. This is reflected in the new Mental Health Act and Mental Capacity Act legislation, and is consistent with an ethos of avoiding inpatient admission or detention under the Mental Health Act where possible. In this context, it is therefore inappropriate to base judgements of the seriousness or severity of mental illness on 'the need for inpatient admission'.
7. We would define 'serious mental illness' as a mental disorder that renders the individual unable to engage constructively in the society, unable to care for themselves and unable to work, ie in relation to the level of impact on function.
8. In our opinion it is also inappropriate to consider inpatient hospitalisation as equivalent to, or as the only alternative to detention centre. We believe this creates a false dichotomy and a revolving door syndrome between detention centre and inpatient admission.
9. It remains of great concern that there are repeated cases where asylum seekers are detained despite a clear and documented history of mental illness and against the specific advice of mental health professionals. (This occurred in both S v Secretary of State and BA v Secretary of State[14], where the judgment concluded that they had suffered serious further deterioration in their mental state as a result of their detention).
10. It is also of great concern that there are repeated examples where mental disorder has not been satisfactorily or adequately managed in the detention centres. These examples have been taken to the High Court and the provision of psychiatric care in these instances was not only found to be woefully below that considered best practice but to be so poor that the overall treatment of the people concerned was found to be inhuman and degrading. . There is no evidence to suggest that practice has changed since these rulings. It is noteworthy that n both the cases cited above, there was also failure to transfer the detainee for compulsory psychiatric treatment. In S v

[14] See note 2

Secretary of State, the judge found UKBA policy was not properly understood and applied by those authorising detention, and that the decision and subsequent reviews failed to assess and understand the impact of detention on S's mental health. In R (D) v Secretary of State[15], the claimant (who had a diagnosis of paranoid schizophrenia), was denied treatment for several months and was segregated despite clearly documented prior knowledge of his illness and current treatment. There was also evidence of neglect and recourse to disciplinary sanctions.

11. It is therefore crucial that clinical and other staff working in detention centres were given adequate training and support to identify mental disorder when it does arise or deteriorate significantly in a detention centre setting, and clear guidelines on how to manage this appropriately and link up with existing local mental health provision outside the detention centre. This should include specific attention to appropriate monitoring and management of risk.

15 R (D) v Secretary of State for the Home Department [2012] EWHC 2501 (Admin)