Positive duty of care? The mental health crisis in immigration detention

A briefing paper by the Mental Health in Immigration Detention Project:

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association of visitors to immigration detainees

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BID is a national charity established in 1999 to improve access to bail for all those held under Immigration Act powers. BID works with asylum seekers and migrants in removal centres and prisons to secure their release from immigration detention through advice, training and representation, helping around 2000 detainees each year. BID also carries out policy, research and litigation work directed towards access to justice for immigration detainees.

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AVID is the national network of volunteer visitors to immigration detainees in the UK. Established in 1994, AVID has over 18 years experience in supporting immigration detainees wherever they are held; our 19 member groups visit in immigration removal centres (IRCs), short term holding facilities (STHFs) and prisons. AVID provides support, resources, information and advocacy to all those who visit immigration detainees. Working with and through our membership, AVID collates evidence of the daily realities of immigration detention and uses this to present a collective voice for change.

The Mental Health in Immigration Detention Project (MHIDP) is a policy initiative which aims to secure the humane and lawful treatment of immigration detainees. It is a joint project by the Association of Visitors to Immigration Detainees (AVID) and Bail for Immigration Detainees (BID). The project was started in 2010 in response to policy changes by the UK Border Agency (UKBA), bringing together the concerns of visitors groups and detention organisations, and drawing on expert advice from specialist lawyers and clinicians.

We believe that people with mental illness should never be subjected to immigration detention.

However, while people with mental illness are being detained, we aim to ensure:

- That they are treated humanely and in accordance with best practice, receiving care equivalent to that found in the community.
- That the UKBA acknowledges its duty of care for people with mental ill health, and exercises that positive duty in accordance with its legal obligations.

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1. Background

Introduction

Immigration detention is the practice of holding individuals and families subject to immigration control in custody, either while they await permission to enter, or prior to deportation or removal from, the country. There is no time limit on immigration detention in the UK, and decisions to detain are not taken by a court but by immigration officials. In the UK there is no regular, independent consideration of release from immigration detention, for example through access to monthly bail hearings.

Detainees can be held in one of ten Immigration Removal Centres (IRCs), in short term holding facilities (STHFs), and in prisons, police custody suites and other holding rooms at ports. Around 30,000 people enter immigration detention every year, around 45% of whom will have claimed asylum at some point[1]. Immigration detainees may be asylum seekers awaiting decisions on their claims or enforced removal from the UK after refusal; migrants facing removal; or foreign nationals who have served a custodial sentence in the UK and are facing deportation. Around 10% of immigration detainees are detained for 12 months or more. When a person is first detained it will not at that point be apparent that their detention may become long-term, but a significant minority will go on to be detained for one or two years, or even longer.

Impact of detention on mental health

It has been acknowledged by the National Clinical Director for Health and Criminal Justice for the Department of Health that custody causes mental distress and acts to exacerbate existing mental health problems, heighten vulnerability and increase the risk of self-harm and suicide. Studies in the criminal justice sector show that there is a greater risk of suicide among certain 'high risk' groups in custody including young adults, males, those who have suffered a previous traumatic experience, and those who do not have family or social support[2]. The UK's immigration detention population includes high proportions of each. It is well documented that the effect of custody on mental health also holds for immigration detention; that the mental wellbeing of both adults and children is damaged by detention, and that the open-ended nature of immigration detention is particularly damaging[3]. One recent study found even higher

[1] Home Office **Immigration Statistics October – December 2011,** available at: http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/immigration-asylum-research/immigration-q4-2011/?view=Standard&pubID=1007858 Detention tables accessed 23rd May 2012

[2] HMIP, (1999), *Suicide is Everyone's Concern: A Thematic Review*, HM Chief Inspector of Prisons for England and Wales

[3] See for example Robjant, K. et al (2009), 'Psychological Distress amongst Immigration Detainees: A cross sectional questionnaire study'. *British Journal of Psychology* 48:275-86; Pourgourides, C. (1997),

levels of suicide and self harm amongst immigration detainees than amongst the prison population[4]. Research from Canada has also shown that detained asylum seekers have higher levels of depression, anxiety and post traumatic stress disorder (PTSD) than asylum seekers in the community[5].

This picture is recognised by staff and volunteers at BID and by the member organisations of AVID, who are in daily and often long-term contact with large numbers of people in immigration detention, as visitors, visitor coordinators and legal advisors.

The last twelve months have seen the first three cases in the UK in which the treatment of severely mentally ill men in detention was found to have been unlawful and to have breached their Article 3 rights (inhuman and degrading treatment)[6]. These are extreme examples of what we believe is a crisis of mental health in immigration detention.

> A visitor at Brook House IRC visited D in early 2011. His health care needs were apparent. His solicitor arranged for D to see a psychologist and for a psychiatric assessment to be carried out, both concluded that D had the mental age of an 11 year old.
>
> Despite this, D was held in isolation in Brook House for six weeks. His visitor told us "he has evidently been emotionally scarred from being detained in isolation for so long".
>
> ***Visitors Group report to AVID, 2011***

Healthcare provision in immigration detention

'The mental health implications of detention of asylum seekers in the UK'. *Psychiatric Bulletin* 21:673-674; Medical Justice, (2010), State *Sponsored Cruelty: Children in Immigration Detention*; London Detainee Support Group (2009) *Detained Lives: the real cost of indefinite detention*; Bail for Immigration Detainees, (2009), *Out of sight, out of mind: experiences of immigration detention in the UK*.

[4] Cohen (2008) 'Safe in our hands? A study of suicide and self harm amongst asylum seekers'. *Journal of Forensic and Legal Medicine* 15 (4):235-6

[5] Cleveland, J. et al (2012) *The impact of detention and temporary status on asylum seekers' mental health*, available at http://bit.ly/MSWzGe

[6] R (HA (Nigeria) v SSHD, HC 2012 available at http://www.bailii.org/ew/cases/EWHC/Admin/2012/979.html ; R (BA) v Secretary of State for the Home Department [2011] EWHC 2748 (Admin) (26 October 2011) available at http://www.bailii.org/ew/cases/EWHC/Admin/2011/2748.html . and R (S) v Secretary of State for the Home Department [2011] EWHC 2120 (Admin) (5 August 2011) available at . http://www.bailii.org/ew/cases/EWHC/Admin/2011/2120.html

Operational management of the immigration detention estate is contracted out by the UK government to commercial operators and HM Prison Service[7]. Currently, provision of healthcare is sub-contracted, resulting in a mixed provision of private and public healthcare systems such as Serco Health, Primecare Forensic Medical, and Saxonbrooke Healthcare, and some NHS provided-care.

Under the current system, there is no centralised healthcare needs assessment in immigration detention; individual healthcare contractors are responsible for carrying out a needs assessment for each centre, and for making decisions on staffing levels. This includes, for example, decisions on the provision of adequate numbers of qualified mental health nurses and clinicians, and the availability of counseling or psychiatric support. As a result, provision for the identification and treatment of mental illness and distress varies enormously between IRCs, as do the type of facilities available in each centre, including provision for dual diagnosis patients. Despite these differences in provision between centres, there is no independent audit of IRC healthcare provision other than contract monitoring carried out by UKBA, which is not the same exercise. As the contract arrangements are not publicly available, there is a total absence of information on how decisions are made and resources allocated by private healthcare contractors operating in IRCs. This has long raised questions about the level of scrutiny and accountability for healthcare providers

Guidance is set out in the statutory instrument the Detention Centre Rules (2001). The rules state that all detention facilities must provide healthcare to a standard equivalent to that found in the community[8]. In relation to guidance on provision of mental health treatment in IRCs, Rule 24 of the Detention Centre Rules (Healthcare Operating Standard)[9] states that

> *The Centre must provide primary care services for the observation, assessment, and management and care of detainees with mental health care needs. Where a detainee presents serious mental health needs the healthcare team must make arrangements for an assessment of that person and facilitate access to secondary care services where required. Detainees must be treated by appropriately trained healthcare professionals in line with national standards and guidance.*

There are no other published guidelines.

[7] Current providers are: Serco, Group 4 Securicor (G4S), Mitie PLC, and the GEO Group.
[8] Detention Centre Rules (2001), available at http://www.legislation.gov.uk/uksi/2001/238/contents/made
[9] *Ibid*

> "Cutting, self-strangulation, food refusal, hair pulling, head banging ….any of these can be a "tool to raise profile".
>
> ***Comment to MHIDP by healthcare contractor, 2011***

Transfer of IRC healthcare commissioning to the Department of Health

UKBA and the Department of Health have agreed in principle that healthcare commissioning for IRCs in England and Wales should move incrementally to the NHS, and a Memorandum of Understanding was signed on 15th August 2010. After a 12 month feasibility study led by the Department of Health both ministers agreed on the transfer of commissioning. In light of the data gaps identified above, it remains unclear how UKBA and the Department of Health propose to assess levels of need and resource allocation for mental healthcare provision in the estate unless a comprehensive needs analysis is carried out at an early stage.

The UKBA has now announced that preparation work for the transfer of healthcare commissioning has started; the process was due to begin in April 2012. Commissioning arrangements will be transferred for an initial group of IRCs, with the experience of this exercise then informing the transfer to the NHS for the remaining centres over a two year period.

At the time of writing, we understand that the Clinical Commissioning Groups created as a result of the reorganisation of the NHS are not yet fully functioning, and are not expected to be in a position to engage in meaningful discussion for some months to come. It would therefore be sensible to expect that the timetable for the transfer of healthcare commissioning for the detention estate to the NHS will extend beyond April 2014.

> "Mental health problems were evident for detainees in many centres, and some had reported significant trauma or torture. However the process intended to provide safeguards to detainees who were not fit to be detained, or had experience of torture, did not appear to be effective"
>
> ***HMIP Annual Report 2010-11***

Information gaps around mental health and detention

UKBA has told us that it neither collects nor holds centrally any data on the number of detainees in the immigration detention estate who have been diagnosed with a mental health condition. This position is reflected in the following response from Immigration Minister Damian Green to a Parliamentary Question, in 2010[10]:

> 'Tom Brake MP: *To ask the Secretary of State for the Home Department how many detainees in each detention centre on the latest date for which figures are available had been diagnosed with a mental health condition. [27804]*
>
> Damian Green: *Consultations and medical records are confidential between patient and doctor. The only exception to this is where a medical practitioner believes a detainee's health is likely to be injuriously affected by continued detention. In such circumstances, he or she is required to inform the UK Border Agency. The Agency is not otherwise informed of, and is therefore unable to provide data on, the number of detainees who are diagnosed with* a *mental health condition*.'

The absence of any centrally held information of this nature makes it impossible to determine the scale of the issue, not just for NGOs and other groups that support or advise detainees but presumably for the UKBA who have a positive duty of care towards those in detention and are required to adequately resource provision for mentally ill detainees.

NGOs and lawyers frequently make requests to the Home Office and Ministry of Justice for disclosure of information under the Freedom of Information (FOI) act in attempts to quantify our concerns, and for legal work. These requests are undermined by the lack of central data collection by UKBA, rendering disclosure requests too costly to fulfill as they would require searches through individual records, confidentiality issues notwithstanding.

A request by the MHIDP to UKBA for disclosure of the number of requests for transfer from IRCs under s2 and s3 of the Mental Health Act in November 2011 was refused as follows:

[10] Hansard HC 2nd December 2010 Column 972Wavailable at http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm101202/text/101202w0002.htm

> *"I can confirm that the information you have requested is held by the healthcare departments within our removal centres but have estimated that the cost of answering your request would exceed the £600 limit and we are therefore unable to comply with it. This is because the information requested is not held centrally and could only be obtained by checking individual medical records at disproportionate costs."*[11]

Other requests for information are thwarted by lack of standarised approaches to data collection. For example, a request for information relating to instances of self-harm across the detention estate is made quarterly by a campaigning group and figures are released under the Freedom of Information (FOI) Act[12]. However, this project has since established that the recording of this data is interpreted in varying ways by healthcare contractors across the estate, rendering the data collated and released by UKBA inaccurate. UKBA have now undertaken to review how this data is collected, and to standardise definitions of terms such as "incident of self-harm requiring medical treatment".

Changes to UKBA guidance on groups considered unsuitable for detention

Policy guidance to UKBA decision makers on groups that should normally be excluded from immigration detention is given in the 'Enforcement Instructions and Guidance' (EIG), a manual of guidance and information for officers dealing with immigration enforcement within the UK. EIG Chapter 55 'Detention & Temporary Release' Section 10 (EIG 55.10), 'Persons considered unsuitable for detention', provides a list of specific categories of person that should be considered suitable for detention '*only in very exceptional circumstances*[13]'. These categories include – though defined more specifically than outlined here - children, the elderly, people who are disabled, pregnant women, victims of trafficking or torture, and people who are mentally ill.

This important guidance was amended without any prior consultation with stakeholders or with the Department of Health in August 2010, when the UKBA introduced a new version of EIG 55.10 that states:

> *"The following are normally considered suitable for detention in only very exceptional circumstances, whether in dedicated immigration detention accommodation or prisons:*

[11] Letter from UKBA Criminal Casework Directorate to BID, dated 1st December 2011.

[12] UKBA data relating to self harm and ACDT (Assessment, Care in Detention and Teamwork) in immigration detention are requested quarterly by www.freemovement.org.uk

[13] See UKBA website at http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/enforcement/detentionandremovals/chapter55.pdf?view=Binary

…

Those suffering serious mental illness which cannot be satisfactorily managed within detention (in CCD cases, please contact the specialist Mentally Disordered Offender Team). 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 are awaiting transfer under the Mental Health Act"

To observers, the effect of this change was to define more narrowly and reduce at a stroke the numbers of people with mental illness who would be considered by UKBA to be unsuitable for detention. To put it another way, the type and degree of mental disorder that, were a person to fit this category, would render them suitable for detention appeared to have widened, and would mean that greater numbers of mentally ill people could now be detained. The new instruction introduced in August 2010 required that a person must be 'suffering from' mental illness (i.e. symptomatic), and would need to have a 'serious' mental illness, before they could be considered possibly unsuitable for detention.

When asked, UKBA were unable to define 'satisfactorily managed' to the Immigration Law Practitioners' Association (ILPA) and NGO stakeholders including AVID, BID, Medical Justice, and Freedom from Torture. Clarity was sought over whether the new guidance meant, for example, that a mentally ill person could continue to be detained until their mental state deteriorated to the point where 'satisfactory management' was no longer possible, at which point they would be considered for release. It was unclear how this policy change would fit with the positive duty of care on the part of UKBA towards those deprived of their liberty.

This significant revision to the guidance was challenged by ILPA, and in response, UKBA noted that the qualifier 'satisfactorily managed'[14]:

"is not defined, nor to we consider it necessary to do so. The phrase is intended to cover the broad basis on which a person's healthcare, mental health or physical needs might need to be met if they were to be detained, with the expectation being that where these needs cannot be met the persons concerned would not normally be suitable for detention"

While the category of person who could now be considered suitable for detention had effectively been widened, it was not clear what new instructions and resources were to be provided by UKBA to those contracted to deliver mental health care in IRCs, or

[14] Written response from Alan Kittle, Director of UKBA Detention Services to ILPA, 20th December 2010

how information would flow from healthcare providers to UKBA to inform decisions to detain, given that new criteria for suitability for detention had been published.

> "The length of detention and uncertainty over cases caused considerable distress. Some detainees continued to be detained for long periods, despite no prospect of their imminent removal. The continued detention of detainees with mental illness was not fully reviewed in accordance with the rules"
>
> ***HMIP on Harmondsworth 2010***

Where the fact of detention is itself a trigger for mental distress, it is impossible to see how such an individual can be *'satisfactorily managed'* in detention. There can be no justification for continued detention in the case of self-harming or suicidal detainees where their immigration case is pre-decision or pre-hearing.

It was these kinds of questions that prompted the launch of the Mental Health in Immigration Detention policy project in late 2010.

M was born in east Africa in 1980. He suffers from chronic disorganised schizophrenia. His mental disorder first came to medical attention in 1999, and he was sectioned under the Mental Health Act on two occasions. A pattern of homelessness, social decline, and criminality followed, and M spent time in prison. He received treatment for schizophrenia while in prison, and had a record of self-harming behaviour in prison.

In 2009 M entered immigration detention, and six months later was admitted to Hillingdon Hospital under s.48 Mental Health Act 1983. He was subsequently discharged from hospital and returned to detention in Harmondsworth IRC. IRC medical notes record that M had initially been prescribed anti-psychotic medication for his schizophrenia, and that he was hearing voices and self-harming.

M was later assessed by an independent consultant psychiatrist. The report noted that M's health had deteriorated as a consequence of detention, and noted real concern for M's health should he remain in detention. M was found not to have the capacity to give instructions. His medical needs were not being adequately met in detention. He was being prescribed with the wrong medication and was not getting the appropriate therapeutic support. The psychiatrist noted that there were long periods when M was not reviewed by a psychiatrist, despite the known fact that J was not taking his medication. The IRC doctor had subsequently stopped the depot antipsychotic injection that M was receiving (having earlier stopped his Olanzapine) and stated in M's medical notes that "no Clinic appointment needed". The independent psychiatrist describes this sequence of decisions as "somewhat alarming".

The independent report further notes that healthcare staff were not actively pursuing mentally ill detainees who were not taking the initiative to ensure they got their medication. He also noted that failure to take steps to manage your own condition is a typical feature of chronic disorganised schizophrenia and related conditions. Healthcare staff may therefore conclude that a detainee no longer requires treatment, despite the fact that failure to continue treatment can be a symptom of certain kinds of mental illness.

Three weeks after this independent assessment, UKBA received a fax from Harmondsworth IRC that stated "the subject is not under any prescribed medication for mental health issues and is fit for detention".

During his detention M was refused release on immigration bail. One of the reasons given by the judge was that M was receiving "at least some treatment" for his mental illness in detention and it was not certain that he would receive any treatment on release. This reflects a pattern of mental illness being seen by judges as a reason for keeping a person in detention. In effect, mental illness has become a justification for continued detention rather than one reason why detention should perhaps not continue.

2. Why the Mental Health in Immigration Detention Project?

Concerns about mental health in detention have grown in recent years among visitors groups and NGOs working daily with people in detention.

AVID has worked to highlight the lack of accountability in healthcare provision in IRCs over several years. Visitors groups increasingly report that detainees they support are experiencing high levels of anxiety and distress, are self harming, have symptoms of depression or post-traumatic stress disorder (PTSD), or are suffering from severe and enduring mental illness. This is in spite of policies intended to protect these groups from the harm of detention. Further, our work in researching provision across the detention estate revealed discrepancies between centres and a lack of policy guidance. AVID is also concerned that where policies do exist, they are often not properly implemented. For example, many detainees with mental health needs are segregated as a method of managing their ill health.

BID's caseworkers routinely work with clients who are distressed and anxious as a result of being detained, who self-harm, or who are severely mentally ill. Some BID clients are mentally ill yet have been segregated as a means of behaviour control, and segregation can complicate legal work to obtain release. BID caseworkers report that it is more difficult to advise and represent someone who is mentally ill. It can take more time to gain their trust, and their capacity to instruct a legal advisor may be difficult to determine. Communication can be more difficult, as can getting documents or taking instructions where a client has disordered thinking.

Where detainees' mental state deteriorates as a result of detention, or because their mental illness has not been identified or "satisfactorily managed" in detention, caseworkers report that it becomes harder for people to help themselves progress their case. Mental illness and mental distress can make it more difficult for detainees to give statements, for legal advisors to discuss a case with clients, and make it more challenging for bail applicants to appear at bail hearings.

Sometimes detainees who are mentally ill or are drug users have become estranged from family or friends who could otherwise stand surety at bail or offer accommodation; their illness or behaviour may have alienated those who are closest to them.

And ironically, actions that might result in release from detention such as applications for bail can create a cycle of expectation and disappointment that can be hard to bear

for long term detainees. A visitor at Brook House IRC explains how the detainee he visits is affected by repeated unsuccessful bail applications:

> *"I've watched him go for and be refused bail, and there's that carousel effect that however much you try to protect yourself against it hopes rise, and are then dashed, and the detainee then becomes very unhappy as you'd expect, but also angry , frustrated, very critical and rightly so of the court process*"[15]

NGO members of the ARC Detention Sub-Group discussed and collated what they perceived to be the key problems in relation to mental illness in the detention estate in late 2010, and these concerns have also informed this policy project.

> "Detainees with mental health or behavioural problems have see-sawed between a healthcare ward and being in segregated accommodation, removed from association. If those who are mentally ill are to be detained appropriate accommodation should be provided"
>
> ***Harmondsworth IMB, 2011***

AVID and BID began a comprehensive policy initiative on mental health in detention in 2010. This involved over a year of research into existing UKBA, Department of Health, Ministry of Justice and healthcare contractor policies and protocols relating to mental health and detention. The research examined mental health care pathways, UKBA instructions to healthcare contractors, mechanisms for managing suicide and self-harm in detention, Mental Health Act transfers, provision of continuing care for mentally ill detainees on release or removal, and legal barriers to release related to mental health such as the statutory ground for refusing release on bail. Other research included submission of FOI requests, analysis of court judgments in unlawful detention cases where mental health was an issue, a number of BID client files, and HM Inspectorate of Prisons (HMIP) reports. We have met repeatedly with IRC healthcare contractors and welfare staff, with GPs who work with released detainees, with UKBA managers and Policy Directors, and legal and clinical experts.

Evidence gathered by the project to date has been used to prepare submissions to consultations by both national and international human rights mechanisms, including

[15] Research respondent V05 cited in Gatwick Detainees Welfare Group, 2012, *'A Prison in the Mind': the mental health implications of detention in Brook House Immigration Removal Centre'*, Crawley: GDWG (forthcoming)

the UK Equality and Human Rights Commission, the UN Special Rapporteur on the Human Rights of Migrants and the UN High Commissioner on Human Rights Universal Periodic Review.

A full list of our findings and key concerns is provided in Section 3.

3. **Mental health and detention: key concerns**

IN RELATION TO DECISIONS TO DETAIN and MENTAL HEALTH CARE IN DETENTION

a. Screening: there are insufficient questions in Rule 34 (the compulsory screening interview) to address vulnerability.

b. Pre-existing severe and enduring mental illness is not always picked up at screening.

c. Problems in healthcare records and access - medical records don't always move with detainees round the detention estate or to the detention estate from prison.

d. The general failure of safeguards such as Rule 35, and erosion of policy safeguards such as UKBA's Enforcement Instructions & Guidance Chapter 55.10 which purport to protect vulnerable people in detention, but are not fit for purpose.

e. The failure of UKBA to follow its own guidelines (e.g. Detention Rules especially Rule 35, and Rule 40 and Rule 42 on the use of removal from association and segregation).

f. Behaviour in detention and mental health – failure to treat mental disorder or mental distress as a mitigating factor, often leading to adverse discipline records with serious consequences for Section 4 bail accommodation allocation, bail summaries, applications for temporary admission, and possible transfer to prison for behavioural reasons.

g. Segregation – the misuse of segregation and prolonged segregation for detainees with mental health diagnoses. Mental illness used as a justification for segregation rather than taken as a contraindication. Many detainees who are mentally ill are held in isolation inappropriately and for long periods as a result.

h. Absence of comprehensive training for IRC staff on mental health, which is, based on the specific needs of a vulnerable, detained population.

i. Failure by UKBA to release from detention when mental health begins to deteriorate. Failure to take steps to facilitate release into the community to access treatment, including where release on bail sought.

j. Tendency by UKBA decision makers to only consider deterioration to the point of needing a Mental Health Act (MHA) transfer as indicating that it is no longer appropriate to detain the individual.

k. Failure by UKBA to arrange MHA transfers in timely fashion and with any sense of urgency.

l. A widespread culture of disbelief and distrust of detainees on the part of UKBA, custody officers, and some healthcare staff. In particular self-harming behaviour is widely viewed as overwhelmingly "profile-raising", situational, goal-directed, or manipulative.

m. UKBA's primary purpose is removal; the culture and working practices are geared towards this, and this feeds in to a distrust of detainees who express mental ill health or a desire to self harm.

n. Lack of publicly available guidance on resource allocation in particular staffing ratios, resulting in inconsistent provision across the estate. Detainees are more or less likely to be able to access, for example: mental health nurses, counselling or psychiatric support, depending on where they are held.

o. In May 2010, BID and AVID recommended to UKBA Detention Services that there be a contractual requirement for healthcare providers to employ a sufficient number of Registered Mental Health Nurses (RMNs). The response was *"it is not a requirement but all providers recognise the desirability of having RMN input and invariably include this in their tenders".*

p. There is no contractual requirement for drug and alcohol screens to routinely be carried out for new detainees, and a lack of clarity over which IRCs offer treatment for drug dependence (detoxification programme or stabilisation/ maintenance prescription for opiate dependence).

q. The stigma of mental distress and mental illness, as in the community, and the unwillingness of some detainees to seek help.

r. No proactive stance by healthcare providers towards detainees who fail to report to receive medication, common to encounter an assumption that such detainees have 'recovered'.

s. Detainees who are distressed, who are self-harming, or who have suicidal thoughts, are monitored and managed in all centres in the first instance by custody officers rather than healthcare staff, through the Assessment, Care in Detention and Teamwork (ACDT) system.

t. There is huge variation in the use of ACDT across the detention estate, with some IRCs employing other systems in parallel to ACDT such as 'RASP' (Raised Awareness Support Plan) at Brook House IRC).

INFORMATION GAPS & AVAILABILITY OF DATA

a. While the nature of the mental health crisis in detention is self-evident, the size of it remains unclear: no estate-wide healthcare needs assessment has been carried out by UKBA.

b. The responsibility for healthcare needs assessments is devolved, and while some healthcare contractors have carried out a healthcare needs assessment these are not made publicly available.

c. There is a general failure by UKBA to acknowledge the specific needs of a detained population and their heightened vulnerability.

d. Data that is made available, such as quarterly figures on instances of self-harm requiring medical treatment, are interpreted differently by different contractors resulting in inaccurate data.

e. Despite the absence of estate-wide data on the numbers of detainees with mental health needs, UKBA is not actively seeking this information. It is not clear how UKBA can exercise their positive duty of care to those in custody who are mentally ill or distressed if it does not know how many there are.

LACK OF STANDARDISATION: GUIDANCE, TRAINING, CARE PATHWAYS, & MENTAL HEALTH ACT TRANSFER PROTOCOLS

a. Chronic dysfunction between UKBA and Primary Care Trusts in relation to their respective responsibilities and duties towards mentally disordered foreign nationals, whether in detention or otherwise.

b. Allocation and acceptance of responsibilities is problematic in the detention estate, due in part to mixed provision between private care providers and NHS.

c. Management: there is no centralised guidance on continuity of care and management of mental health conditions in the detention estate, including transfers to secondary care.

d. Mental health care pathways and end-to-end provision for mental disorder are not standardised across the estate.

e. Failure by healthcare contractors to obtain relevant medical records, to seek or to arrange patient record transfer from prisons.

f. Failure by UKBA to cross-refer medical reports from an immigration case to their management in detention, and between UKBA's Criminal Casework Directorate and the Mentally Disordered Offenders Team when a detainee is transferred to hospital under the Mental Health Act.

g. Widespread failure by UKBA and healthcare contractors to ensure that detainees are provided with adequate information and medical records to ensure continuity of care for chronic medical conditions on release.

BARRIERS TO RELEASE FOR DETAINEES WHO ARE MENTALLY ILL

a. Use of the detained, deteriorating mental state by UKBA as a ground for maintaining detention.

b. Failure by UKBA to take steps to facilitate release into the community to access treatment where clinically indicated, including where release on bail is sought.

c. A recent amendment to Department of Health guidance on s47 and s48 MHA transfers to require a return to detention post-assessment and treatment, which has the effect of removing the option of release to the community where this is clinically indicated.

d. A culture of disbelief among immigration judges and quasi-clinical decision-making by immigration judges at bail hearings, especially in relation to healthcare provision on release in the absence of any evidence.

e. The existence of a statutory ground for refusal of immigration bail on ground of mental illness.

f. UKBA practice of granting temporary admission (TA) to severely ill detainees, where sudden release puts at risk continuity of medical care, compounded by the possibility of destitution where no accommodation and financial support available.

4. PROJECT OBJECTIVES

Following the initial research phase, with the benefit of ongoing expert legal and clinical advice, and in the light of ongoing litigation in this area, the MHIDP has moved on to address the following set of objectives across the spectrum from decisions to detain through to release or removal from the UK. In line with our overall project goal, the Mental Health in Detention Project is now working to:

1. **Challenge the inappropriate detention of those with mental illness by pushing for a presumption against detention of this group to become a feature of UKBA policy and guidance.**
   We are working to ensure UKBA takes proper consideration of mental health in decisions to detain, regardless of how individuals are considered for immigration detention. Considering guidance, policy, and staffing, we are also highlighting the need for UKBA to tackle the ongoing 'culture of disbelief' as relates to suicide and self harm and broader mental health issues.

2. **Close the information gap by pushing for operational protocol and policy to be based on accurate data and standardised, publicly available health needs assessments.**
   We are looking to ensure that UKBA makes available the relevant health needs assessments of the detained population, as well as undertaking centralised collated data using standardised terminology. We believe that resource allocation for those with diagnosed mental illness and at risk of mental illness and distress should be based on this publicly available data.

3. **Ensure standardisation of mental health resource allocation, provision of mental health support, and standardised mental health care pathways. We are also calling for independent oversight of Mental Health Act transfers, operational policies and guidance.**
   We believe that independent oversight of mental health operational policies and protocols/guidance will ensure greater transparency over mental health care pathways, mental health transfers, and resource allocation in detention such as availability of mental health nurses, counselling and psychiatric support, as well as outcomes for detainees. This must be underpinned by standardised, centrally issued and regularly audited guidance.

4. **Achieve removal of legal barriers to release based on mental health**
   We are pushing for the removal of the mental health related statutory restriction on the grant of bail.