APPG on Refugees and APPG on Migrants: Inquiry into the use of Immigration Detention

Response to call for evidence from Mind

Who we are

We're Mind, the mental health charity for England and Wales.

We believe no one should have to face a mental health problem alone. We provide advice and support to empower anyone experiencing a mental health problem. We campaign to improve services, raise awareness and promote understanding.

Our network of over 150 local Minds provides a variety of services, tailored to the needs of each local community. They are independent charities that share Mind's values and adhere to quality standards. We have over 1,600 services across England and Wales and last year provided direct support to over 300,000 people. Services on offer include supported housing, crisis help lines, drop-in centres, counselling, befriending, advocacy, and employment and training schemes.

Mind runs a Legal Advice Service via telephone and email for people based in England and Wales, which processes around 5,000 legal enquiries each year relating to mental health, mental capacity and community care law and disability discrimination. Mind's Legal Team undertakes casework on behalf of Mind.

Mind wants to ensure that people with mental health problems have their voices heard, and are treated fairly, positively and with respect.

Introduction

Mind has significant and relevant experience of the issues raised in this call for evidence. In 1997, with support from the Department of Health, we began work in response to serious concerns raised by people from black and minority ethnic communities about their experiences of mental health care in this country. As part of this, we have worked with refugee organisations and health care providers across England and Wales to improve access to mental healthcare for refugees and asylum seekers. In 2009, we published a report entitled *A Civilised Society: Mental Health Provision for Refugees and Asylum Seekers in England and Wales,* which found that mental healthcare within detention centres was inadequate to deal with the high levels of mental distress experienced by detainees. We went on to make a series of recommendations to the UK Border Agency (UKBA) on this issue, including that it should develop guidelines for mental healthcare provision in immigration detention centres so as to safeguard vulnerable detainees.

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1. What are your views on the current conditions within UK immigration detention centres, including detainees' access to advice and services? Please highlight any areas where you think that improvements could be made.

How far does the current detention system support the needs of vulnerable detainees, including pregnant women, detainees with a disability and young adults?

1.1 The healthcare provided for people with mental health problems in immigration detention is woefully inadequate. This is reflected by the fact that in the last three years, there have been six cases in which judges have found that conditions suffered by mentally ill immigration detainees amounted to inhuman or degrading treatment contrary to Article 3 European Convention on Human Rights.[1]

1.2 In 2010, the Home Office changed the wording of Chapter 55.10 of the Enforcement Instructions and Guidance (EIG) relating to the circumstances in which people with mental health problems should be detained under immigration powers. Prior to the change, the guidance provided that the "mentally ill" would "normally be considered suitable for detention in only very exceptional circumstances."

1.3 The revised wording, which reflects the current position, states "[t]hose suffering from serious mental illness which cannot be satisfactorily managed within detention" are "normally considered suitable for detention in only very exceptional circumstances."

1.4 The previous wording of the policy provided for a presumption against detaining people with mental health problems in immigration removal centres. The rewording of the policy has, in our view, reversed this presumption, with the focus now being on whether a person's mental health problem is "serious" and capable of being "satisfactorily managed" in detention. This fails to take account of the adverse effect that detention can have on mental health.

1.5 We have serious concerns about the wording of the policy and, in October 2012, we were granted permission to intervene in the Secretary of State for the Home Department's appeal against the judgment of Singh J in *R (HA (Nigeria)) v Secretary of State for the Home Department* C4/2012/1238. We filed a detailed statement setting out our concerns about the threshold a mentally ill detainee is required to meet before engaging Chapter 55.10 of the EIG. However, the Secretary of State withdrew her appeal prior to the final hearing, which means that the issues raised remained unresolved.

1.6 In our view, a test of "serious mental illness" is unworkable as the question of what constitutes a "serious mental illness" is not straightforward and will vary from case to case. Historically, the term "serious mental illness" was used to describe people with psychoses, such as schizophrenia or bipolar disorder, but it is now widely accepted

[1] *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); *R (MD) v Secretary of State for the Home Department* [2014] EWHC 2249 (Admin).

that people with these diagnoses are able to function well in the community. Conversely, mental health problems traditionally regarded as less serious, such as anxiety or depression, can have a very disabling effect on people's ability to function in the community. A test based on the perceived level of seriousness of a mental health problem risks excluding people who are incredibly unwell and require high levels of support.

1.7 The question of whether a mental health problem can be described as "satisfactorily managed" is equally problematic. Our view is that the notion of "satisfactory management" in the policy gives rise to a number of difficult and controversial questions, most notably surrounding whether a mental health problem is being satisfactorily managed if it is not being made worse, or whether it is being satisfactorily managed in circumstances where it could be, but is not being, improved or ameliorated.

1.8 In our view, 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.

1.9 Drawing on what is understood and accepted about best practice and clinical guidance, a mental health problem cannot be said to be satisfactorily managed if it could be improved, through treatment or otherwise, but is not being. This is because, in a clinical context, "management" refers to 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. In our view, if the concept of satisfactory management does not include the promotion of improvement or recovery, it falls below the standards that govern mental health care in the community and in hospital.

2. What are the impacts of immigration detention on individuals, family and social networks, and wider communities?

2.1 Immigration detainees tend to be particularly isolated from the outside world. Research has shown that approximately 80% of asylum seekers do not receive any personal contact from family and friends and over half do not have any family or friends in their host country. People kept for more than three months in detention are shown to be particularly isolated.[2] Such isolation has a detrimental impact on detainees' mental health:[3] it is widely recognised that carers, family members and

[2] *Becoming Vulnerable in Detention,* Jesuit Refugee Service, 2010. www.europarl.europa.eu/document/activities/cont/201110/20111014ATT29338/20111014ATT29338EN.pdf

[3] "Safe in our hands? A study of suicide and self-harm in asylum seekers", *Forensic and Legal Medicine* 2008, Juliet Cohen, p.242.

friends provide a great deal of support to people experiencing mental health problems and can have a strong influence on recovery and relapse prevention.[4]

3. There is currently no time limit on immigration detention – in your view what are the impacts (if any) of this?

3.1 The negative effects of detention on mental health are compounded by the long-term or indefinite nature of immigration detention in the United Kingdom. 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.[5] Another study has found that "prolonged detention exerts a long-term impact on the psychological well being" of detainees.[6]

3.2 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."[7] (*sic)*

3.3 The situation is further exacerbated by failed removals which have a huge impact on detainees' anxieties and state of mind.[8]

3.4 Immigration detention is less structured than detention in prison. In one study, interviewees who had served prison sentences prior to being detained under Immigration Act powers all stated that they felt prisons were preferable to IRCs due to the routine and structure in place in prisons, as well as the fact of having a release date.[9] In addition, however, there is a broader point: indeterminate 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. There is no equivalent in long-term immigration detention.

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[4] *Mental Health Services Case for Change for London,* London Health Programmes, NHS, 2011, p.29. www.londonhp.nhs.uk/wp-content/uploads/2011/03/1.-Case-for-change-low-res.pdf

[5] "Mental health implications of detaining asylum seekers: systematic review", *British Journal of Psychiatry* 2009, Katy Robjant, Rita Hassan and Cornelius Katona, p.308.

[6] "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.

[7] *Colnbrook Immigration Removal Centre Annual Report 2012*, Independent Monitoring Board, p.14. www.justice.gov.uk/downloads/publications/corporate-reports/imb/annual-reports-2012/colnbrook-irc-2012.pdf

[8] See, for example, *Yarl's Wood Immigration Removal Centre Annual Report 2012,* Independent Monitoring Board, p.19. www.justice.gov.uk/downloads/publications/corporate-reports/imb/annual-reports-2012/yarls-wood-annual-report.pdf

[9] Experiences of Africans in IRCs in the UK, 2012, *African Health Policy Network,* p.34. www.ahpn.org/Upload/page/96_AHPN_IRC_Research_Report_139.pdf

4. Recommendations for change

4.1 Enforcements Instructions and Guidance

4.1.1 The Royal College of Psychiatrists' overriding view is that people with mental disorders should only be subjected to immigration detention in very exceptional circumstances.[10] We share this view and would prefer a return to the previous wording of the policy - i.e. a presumption that people with mental health problems should not be detained. However, if it is necessary to use a threshold of serious mental illness, we agree with the Royal College of Psychiatrists' suggestion that it should be as follows:

> "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."[11]

4.1.2 The determination of whether a person is experiencing serious mental illness should be a clinical judgment made by appropriately qualified medical staff on a case-by-case basis.

4.1.3 In our view, clinical input is also required in order to determine whether someone's mental health problem can be, or is being, satisfactorily managed in detention. Based on the safeguards used under the Mental Health Act 1983, we would suggest that two clinically qualified staff (for example, an approved mental health practitioner and a registered mental health nurse) should have to attest to whether a person's mental illness could be satisfactorily managed in detention and, if a person is detained, should conduct regular assessments of whether it is in fact being satisfactorily managed.

4.1.4 In line with the principles of recovery, prevention and least restriction, detainees experiencing mental health problems that are caused or exacerbated by detention to the point that they become serious, should be released into the community except in very exceptional circumstances.

4.1.5 It is never appropriate for a person likely to suffer from acute or crisis mental health breakdown to be detained in immigration detention. In the report arising out of our independent inquiry, *Listening to Experience* (2011), we identified the need for crisis mental health services to provide a warm, caring, respectful response in a safe and comfortable environment, something an IRC could rarely, if ever, provide.[12] Furthermore, we are aware of the difficulties in transferring detainees to hospital from immigration removal centres and is of the view that the detention of people at risk of a mental health crisis cannot be justified until speedy pathways to statutory services are guaranteed. It is therefore our view that the EIG*,* or accompanying guidance, should make specific provision in respect of those experiencing, or likely to experience, a mental health crisis.

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[10] *The Royal College of Psychiatrists Position Statement on detention of people with mental disorders in Immigration Removal Centres*, October 2013, p.9. www.rcpsych.ac.uk/pdf/Satisfactory%20Treatment%20in%20Detention%20document%20March%202014%20edit.pdf

[11] Ibid., p.8.

[12] *Listening to Experience,* 2011, Mind.

4.2 Improved healthcare provision

4.2.1 In our view, there needs to be adequate healthcare provision in immigration removal centres which mirrors that which is available in the community and is capable of meeting individuals' needs and promoting recovery.

4.2.2 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 should be available to immigration detainees, including 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.

4.2.3 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. Detainees' access to treatments should be timely, in accordance with the time scales adhered to in community mental health care. A person-centred approach can only be facilitated in immigration removal centres if independent interpreters are available during mental health assessments and consultations and if all information relating to mental health care is provided in a language and format that detainees can access and understand. In the past, "major concern" has been expressed about the lack of consistent use of professional interpreters in immigration removal centres.[13] If mental health care in detention is to be adequate, these concerns must be addressed.

4.2.4 Modern mental health services have adopted the recovery model as an underpinning philosophy of care. This involves a shift away from traditional clinical preoccupations such as managing risk and avoiding relapse, towards new priorities of supporting the person in working towards improvement, wellbeing and recovery.[14]

4.2.5 The cross-government mental health strategy, *No health without mental health* (2011) emphasises the need for prevention and early intervention in mental health care and has as its objectives:

1) More people with mental health problems will recover;
2) More people will have a positive experience of care and support;
3) Fewer people will suffer avoidable harm; and
4) Fewer people will experience stigma and discrimination.[15]

4.2.6 This approach is also reflected in the NHS Outcomes Framework 2013/14, which sets out the outcomes targets for the NHS Commissioning Board.[16]

4.2.7 If mental health care is to be the same in detention as it is in the community, these outcomes and objectives must be applied.

4.3 Guiding principles and standards

[13] "Safe in our hands? A study of suicide and self-harm in asylum seekers", *Forensic and Legal Medicine* 2008, Juliet Cohen, p.243-4.
[14] *Is there a case for change in mental health services in London?,* 2010, NHS Commissioning Support for London, p.1.
[15] *No health without mental health,* 2011, Department of Health, p.6.
[16] *The NHS Outcomes Framework 2014/15,* 2013, Department of Health, p.3.

4.3.1 We consider that there should be a set of standards that apply to the provision of mental health care in immigration detention. These standards should be independently monitored with enforceable recommendations and penalties for non-implementation.

4.3.2 In our view the provision of mental health care in immigration detention should be governed by a similar set of guiding principles as those contained in the Mental Health Act Code of Practice.[17] There should also be a specific chapter in the Code dedicated to immigration detention.

4.3.3 Mental health care in detention should also comply with:

- the Clinical Guidance on *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services* produced NICE[18]
- the national standards set by the Department of Health's *National Service Framework for Mental Health*[19], and
- the Care Quality Commission's *Essential Standards of Quality and Safety*, which is designed to help providers of health care to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people receiving health care services (including immigration detainees) have a right to expect.[20]

4.4 Advocacy

4.4.1 It is our view that people with mental health problems in immigration detention should have access to a trained mental health advocate to assist them in understanding their rights and advocating for appropriate, effective and timely treatment.

4.5 Staff training

4.5.1 We consider that there are grave risks involved in any Home Office policy on mental illness being operated by non-clinically trained immigration staff. In-depth training should be provided to both healthcare staff and Home Office staff who apply the policy. Such training should incorporate:

- the findings of the courts in the cases which have found breaches of Article 3
- compulsory mental health awareness and mental health first aid training. This would help ensure that staff are able to identify those detainees who are developing a mental health problem or whose existing mental health problem is deteriorating
- training on the provision of culturally appropriate mental health care, including awareness of possible variations in the presentation of mental health problems in detainees from different backgrounds
- training on the Mental Health Act 1983 and the Mental Capacity Act 2005, including the differences between them, so that staff understand how the two

[17] Purpose, least restriction, respect, participation, and effectiveness, efficiency and equity.
[18] *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services.*
[19] *National Service Framework for Mental Health,* 1999, Department of Health, p.3-5.
[20] *Essential Standards of Quality and Safety,* 2010, Care Quality Commission.

statutory regimes relate to each other and can recognise a situation where a detainee's capacity needs to be assessed, and
- training on the use of de-escalation techniques.

4.5.2 In our view, the transfer of responsibility for the provision of healthcare in IRCs from the Home Office to NHS England provides an ideal opportunity for the implementation of a comprehensive training programme for staff.

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