Review of Mental Health Issues in Immigration Removal Centres

Immigration & Border Policy Directorate, The Home Office

A report prepared for Home Office by Dr David Lawlor, Dr Mannie Sher and Dr Milena Stateva

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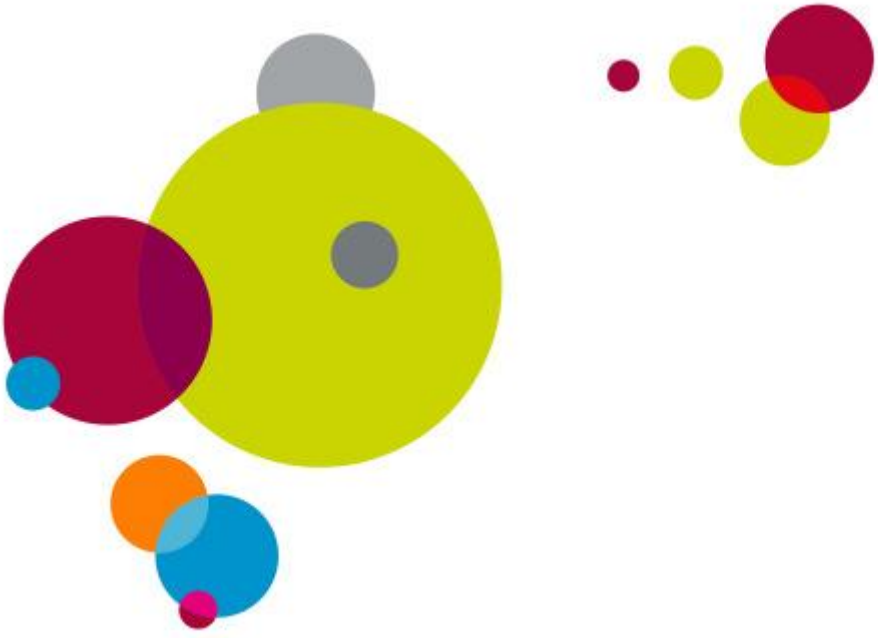

1. Introduction

1.1 The Home Office uses detention as a means of ensuring that those who seek to enter or stay in the UK illegally are prevented and deterred from doing so. It has, however, a legal duty to ensure that it deals humanely with all individuals who are detained, in particular those who might be considered vulnerable. This, of course, includes individuals held in immigration detention suffering from mental health conditions.

1.2 Home Office detention policy, set out in Chapter 55 of the Home Office Enforcement Instructions and Guidance, states that certain categories of persons are normally considered suitable for detention only in very exceptional circumstances. This includes *"those suffering from serious mental illnesses which cannot be satisfactorily managed in detention".*

1.3 The presence of mental health issues, even serious conditions, does not however automatically preclude detention according to Home Office policy. For example, it may be that a person could have a serious mental health condition managed satisfactorily, whilst being detained in order to effect their scheduled deportation with in short period of time. That detention might, however, be contraindicated for a more prolonged period.

1.4 In addition, the policy also provides for very exceptional circumstances where it might nevertheless prove necessary to detain an individual suffering from a serious mental health issue which cannot be managed satisfactorily in detention. For example, in cases involving former foreign national offenders cases the risk of further offending or harm to the public must be carefully weighed against the reason why the individual may be unsuitable for detention.

1.5 This is a very complex area. The Home Office accepts that the experience of detention can be inherently stressful, particularly for those faced with the prospect of their enforced removal from the UK. As a result, it can exacerbate existing mental health conditions. Home Office staff, who are not medically qualified, are required to make to make extremely difficult decisions, frequently having to balance the needs of individual detainees with the need to protect the public and to uphold immigration laws. In addition, mental illness covers a wide spectrum, and detainees can be unwilling to disclose previous mental health problems to healthcare staff in immigration removal centres. Although all immigration removal centres have 24 hour healthcare cover, it is not possible to provide the full range of services to treat mental health conditions that would be available to patients in hospital or in the community.

1.6 The Home Office accepts that it has not always got decisions right on the detention of those with mental health conditions: there have been a number of successful legal challenges to policy in this area in recent years. Indeed, as the Government stated in the response to the 8th HASC Report on the work of the former UK Border Agency (April –June 2012), published on 21 March 2013, where things go wrong in individual cases, it is keen to learn from the experience and, where necessary, make improvements to policies and processes.

1.7 With this in mind, the Home Office engaged the Tavistock Institute of Human Relations, leaders in the field of the application of social science research to contemporary issues, to undertake a review into the way that mental health issues are dealt with in immigration detention.

1.8 This report sets out the initial findings and recommendations of the Tavistock Institute in order to help shape future work and to improve the treatment of those with mental health issues whilst also ensuring that the Home Office is able to maintain a robust system of immigration enforcement, which continues to include the use of detention where necessary.

1.9 It is important to note, also, that since this report was commissioned and the research done, responsibility for healthcare commissioning in the detention estate has transferred to the NHS – in most centres from 1 September.

2. Terms of Reference

2.1 In asking the Tavistock Institute to carry out this Review, the Home Office agreed the following terms of reference for the work.

Summary

2.2 The purpose of the Review is to consider how Home Office policy on dealing with mental health issues in immigration detention, and how that policy is put into practice, can be improved in order to improve the well-being of detainees and so that fewer cases end up in legal challenge.

Detail

2.3 The following will be key issues for the review to consider:

- the difficulty of identifying mental health issues for both trained experienced psychiatrists and detention healthcare staff;
- the difficulty of seeking timely specialist psychiatric help;
- how to improve communication processes between detention staff and caseworkers; and
- how to improve caseworkers' understanding of the implications of detainees' mental health on their decision-making.

2.4 The objectives of the Review therefore will be:

- to consider what can be done to improve:
    - the identification and treatment of mental health issues in removal centres;
    - the way in which mental health issues are taken into account in caseworkers' decision making; and
    - communication between removal centres, caseworkers and NHS trusts; and
- to provide a summary of findings setting out areas where improvements can be made and what needs to be done to effect them.

2.5 In achieving these, the Review will want to consider the following key questions:

- on removal centres:
    - how can mental health issues be better identified within the context of the detention estate?
    - are the current reporting mechanisms clear and of sufficient detail?
    - how can provision of healthcare be improved?
- on casework:
    - in what ways can caseworker understanding of mental health issues and their impact on people in detention be improved?
    - are the processes robust for consideration of mental health issues at key decision points - initial referral, detention reviews, etc…?

3. Executive Summary

3.1 The Home Office has a well-developed range of policies and procedures relating to detention and case-working, which do not always work smoothly in practice.

3.2 Difficulties surrounding mental health issues of detainees in the Immigration Return Centres (IRCs) are linked to the complexity inherent in the system**.**

3.3 IRCs have two main priorities: firstly, helping to effect the speedy removal of those who are in the country illegally; and, secondly, ensuring the welfare of individuals while in detention. The needs of these two priorities and the Home Office structures in place to deliver them both can lead to internal organisational conflict which leads to being less effective and efficient at both.

3.4 The relationships between policy makers, managers, detention centre custody staff, healthcare staff and caseworkers may sometimes be characterised by a degree of mutual defensiveness.

3.5 Mutual antagonism and suspicion operate in the relationships between the Home Office and some non-governmental organisations (NGOs), official oversight bodies and voluntary organisations operating in the sector.

3.6 Detention itself can create highly stressful situations for detainees and staff alike. Building of unrealistic expectations as to the likelihood of staying in the UK by those advising them can also lead to increased uncertainty and stress for detainees.

3.7 Vulnerable detainees may deteriorate in a detention situation where caseworkers, sub-contractors, solicitors and other agencies are often in disagreement with one another and thus feeding the detainees' sense of powerlessness, hopelessness and fear of the future.

3.8 Psychological talking therapies are scarce in the IRCs. This therapeutic approach has been used elsewhere to prevent or relieve serious psychiatric breakdown.

3.9 Because of the underlying defensive dynamic, the current 'culture/s'[1] in the IRCs will likely continue unchanged. The provision of training, more staff, different providers and other inputs, will likely be incorporated into the existing defensive culture/s. Therefore no real change is likely to take place.

3.10 The Home Office's and IRCs' culture of 'detention' should be shifted towards a culture of 'temporary transitional institution' with the primary task of aiding,

[1] The concept of organisational climate is well described by Schein, E.H. (1992). Organisational Culture and Leadership. (2nd ed) San Francisco, California: Jossey-Bass

helping and preparing detainees to be returned to their countries of origin. This would be a culture-changing initiative.

4. Key Findings and Recommendations

Identification of mental health issues and culture change

4.1 **Training** – The current provision of training on mental health awareness and appropriate treatment is very limited, leading to Home Office staff engaging with people who are detained without the skills necessary to be able to identify existing mental health issues.

Recommendation 1: Appropriate levels of training in mental health awareness and appreciation of when specialist treatment is required should be extended to all staff who have contact with, or make decisions in relation to, people who are detained.

4.2 **Mental health assessment** – In the healthcare assessment carried out on arrival at IRCs, more attention needs to be paid to the person's previous mental health condition and any history that is available in order to provide better psychiatric oversight at the start of the detention process.

Recommendation 2: The provision of more staff qualified in assessing the individual's previous mental health condition and history, e.g. Registered Mental Nurses (RMN).

4.3 **Following assessment and admission** – There are issues around the non-integration of the different elements of the teams working in IRCs and a lack of a shared understanding of mental health issues. The preferred model of work for managing and treating mental health in the community is the use of the multi-disciplinary team.

Recommendation 3: As far as is possible, multi-disciplinary teams should be established in the IRCs. The ideal membership of the multi-disciplinary teams would consist of custody staff, social workers (if possible), counsellors, psychologists, caseworkers and faith leaders.

4.4 **Task alignment** – Home Office detention centre policies and procedures need to be better aligned to the identification and management of mental health issues. IRCs need to adopt new behaviours and practices that emphasise the two aspects of the organisational task – (i) detention and (ii) return combined with care and welfare.

Recommendation 4: There should be a pilot project in an identified IRC to embed a new task culture that integrates the task of detention and return

with care and welfare to drive improvements in the identification of mental health and its management.

Treatment of identified mental health issues

4.5 **Practical changes in operational approach** – There are various practical and emotional issues for staff, including in relation to the relationship between healthcare and detention staff, and the needs of different detainees, which have been raised in the course of gathering evidence. Several of these can affect the treatment of those with mental health issues in IRCs and add to the general complexity of the situation. For example, health care staff reported that detainees' mental health issues were often linked to uncertainty over their position in regards to return; detention custody staff can find the consequent emotional demands on them challenging. Healthcare staff report feeling overwhelmed and exhausted by the volume of cases and demands made on them. Healthcare staff also said that there can be problems in the use of medication – on the one hand, it can be an important resource for alleviating mental illness, but on the other, side effects and errors may occur and the medication needs close monitoring. All this needs to be taken into account in health care commissioning arrangements with the NHS to help caseworkers understand mental health issues among detainees.

Recommendation 5: Detention custody staff need more sophisticated working relationships with healthcare staff to prevent flaws with medication, delayed care, etc. All staff should be better acquainted through training with the diversity of the detainees, i.e. the wide variety of cultures, faiths, disadvantaged backgrounds; the effects of loss and bereavement on a person's mental health. The work of detention custody staff and healthcare staff in IRCs can be improved through considering changes to address the following practical issues in their operational approach:

- **understanding the difficult arena and the complicated task of the application of immigration legislation and the complexity of the unique population;**
- **a commitment to working with the emotional well-being of detainees to promote their mental health;**
- **establishing a more effective administrative and communications process between custody staff and healthcare staff;**
- **there is a need to improve the screening for mental health problems at reception. If IRCs do not carry out the same level of assessment as prisons, especially with respect to risk of self-harm, this could impact on the mental health of detainees;**

- **if health screening at reception is carried out at night time, and often after a lengthy journey, detainees' answers may well not reflect the true state of their health;**
- **if the majority of screenings are done by languageline or with no interpreter, it may lead to inaccurate assessments of detainees' mental health;**
- **attention needs to be paid to the possible insufficient RMN assessments and referral to psychiatric units;**
- **it was reported that monitoring information for patients on ACDT is done on the wing by detention custody staff who are not clinically trained. Their notes are not in the healthcare system, so when doctors assess patients who are being monitored for self-harm risk in the healthcare centre, healthcare staff there do not know what information is held on the ACDT system. Consequently, it may be difficult to find out this information and integrate the systems;**
- **it is reported that the 'culture of disbelief' is pervasive in IRCs and affects how staff assess health complaints and especially self-harm, which can be viewed by some staff as attention-seeking behavior;**
- **the problem of compromised dual obligation of healthcare staff who are employed by an outsourced agency may impact of the standards of their assessment. Standards should be benchmarked against the equivalent NHS and/or prisons services.**

Interaction between different parts of the organisation

4.6 **Reporting mechanisms weakened by complexity in case-working processes** – a number of casework teams from different parts of the business are likely to have worked on any detainee's case as it goes through the system for return. There is a fragmented information-gathering and decision-making process between case-working teams. Case-work staff are the decision makers but they are dependent on detention custody staff and healthcare staff, whom they seldom meet, to keep them informed of the current situations of detainees. The complexity of this casework process can lead to incorrect information being passed along, poor recording and wrong decisions being made. As the immigration return system comprises a large number of tasks, reporting mechanisms are complex, requiring collaboration with public protection agencies like the police, courts and prisons the NHS and local authorities. This often leads to variable and sometimes conflicting communications in reporting processes and consequently decision making can be challenging. There are a large number of boundary transactions in reporting and decision making - upwards of 30 transactions across internal organisational boundaries, involving many people and departments – in order to assess an individual detainee's needs, reach a decision and develop and enforce care plans and/or return.

The number of transactions involves delay in decision-making, which can cause deterioration in the mental health of the detainee. Mental health problems usually need immediate attention. The difficulties in the reporting mechanisms hinder this. Additionally, the adverse combination of these elements can lead to negative consequences for the Home Office and litigation under Article 3.

Recommendation 6: The system needs to be simplified to reduce the volume of transactions and the inevitable misunderstandings and delays that take place with the current structure. Looking at the various sub-system relationships in operation and how to reduce the multiple hand-offs between different parts of the business may be the best way to address these issues.

Improving caseworker understanding of mental health issues and their impact on people in detention

4.7 **Training** – As an example, the Mentally Disordered Offenders case work team had not received specialist training in the handling of cases with serious mental health problems. They have no qualifications, no medical training and insufficient access to advice and support.

Recommendation 7: Psychiatric advice should be available to the team in order to provide a stronger basis for decision-making. The criminal cases case-workers need more training in mental health. Size of caseload for staff –i.e. average number of cases per case owner – should be reviewed as, often, one or two complex cases can dominate a caseworker's caseload. This may lead to lack of oversight of other problematic cases. This may well apply to the National Returns Command, Third Country Unit, Returns Casework, Enforcement, Judicial Review and Litigation Team.

4.8 **Weaknesses and good practice** – Tavistock observed that many casework teams worked effectively, such as in the Detained Fast Track. Policies and procedures for caseworkers were in place and working satisfactorily. However, caseworkers and case owners said the 'complexity in the system' made the work more difficult than it needed to be because it was often difficult for them to keep a 'whole picture' perspective. Home Office and IRC management referred to inconsistent boundary situations at several levels, complicated by the internal flux around restructuring organisational processes going on at the moment. Fragmentation in the overall system is experienced at many levels and leads to misunderstanding, miscommunications and lack of follow-through that impact on detainees' and welfare and mental health.

4.9 Examples of good practice in relation to mental health from elsewhere in the public sector that could be replicated for caseworkers are:

- if multi-disciplinary teams were created as recommended above they could be a single point of contact for case workers over mental health issues;
- IRCs could reproduce the work pattern from prisons, i.e. prisoners with mental health issues are generally managed using a procedure known as assessment, care-in-custody and teamwork (ACCT);
- there is a review system in place that functions 24-hourly/weekly/fortnightly/three-weekly/and monthly, as needed; and
- ad hoc reviews can be arranged.

Recommendation 8: In order to improve caseworker understanding of mental health issues and their impact on people in detention, we recommend a review is conducted of the structures and working relationships between sub-systems within the IRCs; between IRCs and other Home Office departments; between Home Office departments and other external institutions, organisations, companies and agencies; and between the IRCs themselves which have different ethos, arrangements and treatment approaches to mental health problems.

Making the processes for consideration of mental health issues at key decision points - initial referral, detention reviews – more robust

4.10 **Complexity in the system** – There is a complex casework process involving a number of case-work teams working with the detainees on their journey through the system for return, which results in the processes not being robust enough for the consideration of mental health issues at key decision points. For instance, there is split functioning of information gathering and decision-making between case-working teams. Croydon case-work staff are the decision-makers who are dependent on detention custody staff and healthcare staff, whom they seldom meet, to keep them informed of the current situations of detainees. The complexity of this casework process can lead to incorrect information being passed along, poor recording, and wrong decisions being made. The adverse combination of these elements can lead to poor decision-making and therefore negative consequences for both Home Office and detainees concerning their mental health and this sometimes may lead to litigation under Article 3. There is a deleterious diffusion of responsibility that results from any one caseworker being involved with a multiplicity of detainees and their cases. This may lead to inaccurate information being placed on the record and poor decision-making in relation to detainees' mental health and their future health care.

Recommendation 9: We recommend shortening the literal and structural disconnection from the health care workers in IRCs with their casework colleagues, plus having more direct contact with other agencies to

mitigate the impact on detainees mental health when flights are cancelled, vehicles delayed, etc.

4.11 Detainees are falling between structures and systems because of varying lengths of stay lasting, in many instances, weeks, months or sometimes, but rarely, years. Foreign national criminal cases can take longer. The process works well for Fast Track cases, but delays in the system and layers of repeated appeals and re-applications to prevent removal continue the state of uncertainty for the detainee which brings with it greater risk of mental health problems. IRCs are often faced with practical problems not of their making regarding detainees' return, which can delay things further, e.g. complicated relationships with Health Trusts and the Ministry of Justice. Previous protests, e.g. food and fluid refusals and other protests, copy-cat behaviour and refusal to cooperate, may lead detainees to be moved from one IRC or health or prison service to another without proper information exchange systems in place.

4.12 These situations of detainees falling between structures and delays inherent in the current system impact on key decision points such as initial referral and detention reviews and cause concern and misunderstandings for caseworkers who are the decision-makers. For example, the Mentally Disordered Offender teams' caseworkers fear that errors may result in offenders committing a serious offence, such as murder. Secondly, there are also the simple risks of delays in returns decision-making that can exacerbate individual mental health situations of detainees. Criminal case owners described situations in which case owners have waited months for information and a response from other IRCs, doctors, solicitors, etc. These breakdowns at points of key decision-making add to the possibilities of detainees falling between structures and systems and their mental health deteriorating.

Recommendation 10: Boundary transactions are again problematic and need attention. As said previously, the number of transactions across a boundary increase the probability that key decision points are open to failure. This will lead to poor decision-making on the management of individual detainees and their mental health. To address this problem, a review of the sub-system structure should focus on key decision points and the location of the decision-making to reduce the numbers of staff involved in any one decision.

External Relationships

4.13 Relationship with external stakeholders – The working relationship between the Home Office and external stakeholders has all but broken down in some instances. There is mistrust on both sides at both the strategic and local levels

– i.e. between campaigning organisations and policy developers, and between those representing/advising detainees and caseworkers/detention centre staff. These types of relationship lead to opportunities to work together to improve the system identifying and treating mental health issues being missed. They can also directly impact negatively on the mental health of detainees as a result of an unwillingness by those advising detainees to engage with legitimate decisions to return an individual to their country of origin and, instead, raising unrealistic expectations around the prospect of over-turning that decision.

Recommendation 11: mechanisms need to be established for improving the working relationship with external stakeholders in order to make use of experiences, suggestions and actions that will promote the mental welfare of detainees.

Appendix I Project methodology

I.1 Timeline of the Review

In January 2013 the Tavistock Institute of Human Relations was invited to meet with Jeremy Oppenheim, a Director in the Immigration Directorate of the Home Office, to discuss a review of the care of the mentally ill in IRCs. Following this, the Tavistock Institute was commissioned to provide a review. A Joint Steering Group (JSG) made of relevant managers from the Immigration Directorate was constituted to manage the review. The JSG met for the first time in February 2013. A series of meetings were agreed. Three IRCs were identified as sites for the review – Yarl's Wood, Colnbrook and Harmondsworth. Visits were made to Colnbrook and Harmondsworth in July and Yarl's Wood in September. During the same period several meetings took place with caseworkers in Croydon. A half-day workshop was conducted with external NGO stakeholders and official oversight bodies in October. Interviews with doctors took place in December and January 2014. Regular meetings were held with the senior managers from the Immigration and Border Policy Directorate in November and January. The final report was delivered in February 2014.

I.2 Methodology employed – Action Research

The methodology we employed was based on principles of action research. Action research is known by many other names, including participatory research, collaborative inquiry, emancipatory research, action learning, and contextual action research, but all are variations on a theme. Put simply, action research is "learning by doing" - a group of people identify a problem, do something to resolve it, see how successful their efforts are, and if not satisfied, try again. While this is the essence of the approach, there are other key attributes of action research that differentiate it from common problem-solving activities that we all engage in every day. A more succinct definition is:

> 'Action research...aims to contribute both to the practical concerns of people in an immediate problematic situation and to further the goals of social science simultaneously. Thus, there is a dual commitment in action research to study a system and concurrently to collaborate with members of the system in changing it in what is together regarded as a desirable direction. Accomplishing this twin goal requires the active collaboration of researcher and client, and thus it stresses the importance of co-learning as a primary aspect of the research process'[2].

Groups of people interviewed were:

- Detainees
- IRC Managers
- Detention centre custody staff
- Healthcare staff
- On-site caseworkers and Croydon caseworkers
- Medical practitioners

[2] Thomas Gilmore, Jim Krantz and Rafael Ramirez, "Action Based Modes of Inquiry and the Host-Researcher Relationship," Consultation 5.3 (Fall 1986): 161.

- NGOs and official oversight bodies

The Review design was grounded in visits of the above centres and exploration of the experience of working with mental health problems.

- This was achieved by interviews and focus groups exploring their experiences of working with mental health problems; feedback to centre staff on our observations and hypotheses as they emerged.
- We spent a day in each centre.
- This work was complemented and triangulated by focus groups with caseworkers in Croydon.
- A half-day workshop was held with NGO stakeholders and official oversight bodies

I.3 Joint Steering Group

The Joint Steering Group functions were to:

- Oversee and provide directional guidance to the project
- Agree the terms of the review
- Agree timescales for the report
- Bridge the gap between the project and the wider Home Office, providing information on related projects
- Monitor progress of the review
- Raise matters of concern
- Reflect on the emerging themes as these were fed back by the Tavistock Institute team.