

REPORT

Centre for
Mental Health



Immigration Removal Centres in England

A mental health needs analysis

Dr Graham Durcan, Jessica Stubbs and Dr Jed Boardman

Contents

	Executive summary	3
1	Introduction	6
2	Mental health and detention	8
3	Methods	9
4	Description of the IRCs	12
5	The review findings	14
6	Impact of detention on mental wellbeing	17
7	Services in place across the IRCs	19
8	Good, promising and well received practice	24
9	Challenges	27
10	The Commissioning Specification Template	34
11	Discussion and conclusion	35
12	Recommendations	38
	References	
	Appendices	

Acknowledgements

Kate Davies OBE (NHS England), Clare Checksfield (Home Office), Chris Kelly (NHS England), Claire Gipson (Home Office), Nicholas Watkin (NHS England), Angela Hawley (Department of Health), Terry Gibbs (Home Office), Alan Gibson (Home Office), Patricia Cadden (NHS England), Claire Weston (NHS England), Erica Vanklaveren (Home Office), Hong Tan (NHS England), Natalie Pemberton (Department of Health), Anthony Nichols (NHS England), Chris Petch (NHS England), Professor Rosie Meek (Royal Holloway University of London), Gwen Lewis (Royal Holloway University of London), Helen Adam (Dungavel IRC), Elaine Grieve (Campsfield House IRC), Sandra Galver (Gatwick IRCs), Stella Simpson & Victor Igodifo (Heathrow IRCs), Helen Daykin (Morton Hall IRC), Deborah Heaphy (Yarl’s Wood IRC), Dr Hilary Pickles (public health consultant), Dr Cornelius Katona (Helen Bamber Foundation), and Theresa Schleicher (Medical Justice).

Executive Summary

Between March 2015 and March 2016, over 30,000 people were held in UK immigration detention. Many of these people had experienced torture, trauma and oppression in their countries of origin.

In response to the Shaw Report (2016) which highlighted the poor mental wellbeing of people detained in Immigration Removal Centres (IRCs), Centre for Mental Health was commissioned by NHS England to conduct a rapid mental health needs analysis of IRCs in England. The resulting review aims to support NHS England and the Home Office in planning to meet the wellbeing and mental health needs of people held in IRCs.

To gain a full oversight of mental health needs in IRCs, we conducted interviews with staff and detainees, asked managers to complete a survey, and conducted observations of each IRC. Ten IRCs (or 'holding facilities') were included in the needs analysis.

Mental health and immigration detention

Research into the impact of detention has consistently highlighted that:

- Immigration detention has a negative impact on mental health
- The longer someone spends in detention, the more negative an impact it has upon their mental health
- Depression, anxiety and post-traumatic stress disorder are the most common mental health problems

A study conducted across four UK IRCs in 2009 found that four out of five detainees met a clinical threshold for depression.

Mental wellbeing in IRCs

All immigration detainees will face challenges to their wellbeing during their stay. Even if they do not reach a clinical threshold, the distress they experience is still disabling and even life-threatening.

Across the IRCs in our needs analysis, the most commonly reported problem was depressed mood and anxiety problems, and the most

severe reported problems were hallucinations or delusions. Most of the detainees we interviewed had experienced some form of trauma in their life before detention, e.g. fleeing a country where they were being persecuted; witnessing loved ones being killed; experiencing domestic violence, sex trafficking or female genital mutilation; or fleeing a death sentence. They also highlighted issues of mental health stigma and language barriers in discussing wellbeing.

Impact of detention on mental wellbeing

Detainees and staff both described the impact of detention on people's wellbeing. The challenges to wellbeing were partly caused by loss of liberty, the feeling of staying in a prison-like regime, and uncertainty about their future. Additionally, confusion about the legal procedures caused a huge amount of distress to detainees.

"Being here is reliving my trauma because it feels like the captivity I experienced when I was a sex slave..."

"Things I've buried deep inside I'm having to share and now I'm reliving my past. But I don't feel as if I get any support for this..."

"I have never committed a crime and they...left me in a police cell"

Services in IRCs

The mental health provision across the IRCs we visited varied significantly from centre to centre, from predominantly medication management, to varying psychological therapy provision and emotional wellbeing groups. Especially well-received practice included:

- Psychological interventions (as it was generally recognised that the primary need across the IRC estate was for talking treatments)
- Wellbeing groups
- 'One contact' approaches (useful in situations where the length of detention stay is unknown)

- Psychological formulations to understand the context and needs of the individual
- The support offered by chaplaincy teams and religious groups

Most of the centres were developing or had plans for developing Improving Access to Psychological Therapies (IAPT) type services, similar to those available in the community. These services will need to be adapted to meet the specific needs of the IRC population, taking account of language, culture and short and unpredictable durations of stay.

Challenges

A wide range of challenges exacerbate the difficulties experienced by detainees and staff in IRCs. Despite an expressed desire from NHS England and the Home Office that vulnerable people should not be detained, there is no clinical screening in place to detect vulnerability before deciding to detain an individual.

Most detainees perceived that they were not listened to, not taken seriously and treated as if they were lying if they disclosed vulnerability to either health care or security staff. And some staff members reported that it was easy to become part of a culture which disbelieved detainees.

Mental health care staff face a number of ethical challenges in working with immigration detainees, including ensuring continuity of care for those being 'removed' and even for those being released (always at short notice) to the community; but also in maintaining therapeutic relationships when a decision to 'remove' a detainee is withheld by Home Office Immigration Enforcement (often due to a perception that such knowledge increases risk of risk of self-harm and suicide).

Conclusions

Many detainees have experienced multiple traumas, the effect of which can all be exacerbated in detention. They have no certainty over their future and have limited ways to vent their anxiety and frustration.

Whilst many detainees may not meet a threshold for a mental health service, it is important to recognise the challenges to their mental wellbeing and impact of detention on mental distress.

All IRC mental health services need to make improvements to become genuinely psychologically informed services. Most services currently focus more on the medical aspects of mental health care, despite the bulk of need being for talking therapies and improvement or maintenance of wellbeing. Opportunities for detainees to manage and express their feelings are very important and need expansion across IRCs.

Recommendations

People with marked vulnerability should not be subject to detention. Where possible this should be identified before detention. Where vulnerability is identified after detention, a detainee should be provided with appropriate care and support away from the IRC without delay.

Mental health and wellbeing screening

1. Prison mental health teams and Liaison and Diversion services in courts should ensure that information on detained immigrants' wellbeing and vulnerability is passed on to health teams in IRCs and, where appropriate, they need to raise concerns during the detention decision making process. This should be reflected in the operating models and guidance for Liaison and Diversion services and prison mental health teams.
2. IRCs require a standardised approach to mental health screening.
3. Any detainee should be offered a review of their mental wellbeing once they have been detained for more than 30 days and at three-month intervals thereafter.

Mental health and wellbeing support

1. All IRC mental health services should have a wellbeing focus and deliver the stepped care model. All commissioners need to rigorously ensure that services reflect the stepped care model and that there is an appropriate balance between psychological offers of care and psychiatric and medical care, with the greatest emphasis placed on the former and clear pathways for those requiring specialist care.
2. Access to alternatives to psychological intervention such as relaxation therapy should be increased.
3. IRCs holding women should demonstrate that they have an appropriate gender-specific response that reflects the different needs and context of women in detention. Treatment pathways for those experiencing trauma should be specified.
4. There should be a review of NICE guideline compliance, particularly with regard to the assessment and treatment of trauma.
5. We recommend that the availability of time-limited psychological interventions should be increased across all establishments. Future Health Needs Assessments at IRCs should be required to provide more specific guidance on the resource required for each element of the Stepped care Model.
6. Peer support interventions should be developed, including the potential for peer mentoring.

Staffing levels

1. All IRCs should have access to expertise that can guide appropriate interventions for supporting detainees managing the experience of trauma.
2. All IRCs should have ready access to a mental health crisis response 24/7. This can either be through having appropriately trained staff at night as well as during the day, or via a responsive on-call service during the night.

3. All IRCs should have access to mental health practitioners who solely have mental health related duties. This means that one or more staff as appropriate has a dedicated mental health function that is not secondary to a general health function for daytime shifts, seven days a week.

Staff training and development

1. All staff in IRCs should be trained in their role within the Stepped care Model, and mental health practitioners should receive access to training and clinical updating.
2. All mental health care practitioners should be provided with robust clinical supervision and have access to both peer supervision and one to one supervision at least once per month.
3. Mental health awareness training should be mandatory for all new IRC staff as part of their induction and all staff should have mandatory annual update training.
4. A forum should be created across all IRCs to allow for the sharing of good and evidence based practice between practitioners from different institutions.

Continuity of care

1. IRC health care staff should be given maximum possible notice of release to ensure continuity of care for the most vulnerable detainees (i.e. those at risk of relapse in health if released without an active care plan in place).
2. Planning continuity of care and access to appropriate mental health treatment for detainees following their removal (e.g. discovering whether their medication is available in their country of origin) should be centrally managed within the NHS and not the sole responsibility of individual IRC health care teams.

1. Introduction

Background to the report

This report, written by Centre for Mental Health, has been commissioned by NHS England and supported by the Home Office. NHS England are responsible for commissioning all health care provision in Immigration Removal Centres (IRCs)¹ in England. Centre for Mental Health was asked to conduct a rapid mental health needs analysis of IRCs in England. The analysis was commissioned in response to a report (the Shaw Report, 2016) written by Stephen Shaw, the former Prison and Probation Ombudsman, which reviewed the welfare of vulnerable people held in IRCs, and had highlighted particular concerns for the mental wellbeing of immigration detainees.

This review was confined to IRCs in England, though it is reasonable to assume that the findings and recommendations may also apply, at least in principle, to the one IRC outside England. We also visited Dungavel IRC in South Lanarkshire to speak to health providers and observe practice. The visit to Dungavel took place separately to the NHSE commissioned work.

Centre for Mental Health conducted the mental health needs analysis between mid-February and early April 2016.

Immigration Removal Centres

“UK-wide immigration legislation provides that a person can be detained in certain circumstances for the purposes of immigration control. This does not mean that a person will be detained automatically, and as a matter of policy there is always a presumption against detention.

Those who are liable to be detained in IRCs include those who have been detained to effect their removal from the UK including time served foreign national offenders; persons subject to immigration control whose identity or basis of claim needs to be established; and where it is believed that a person will not comply with their temporary release or admission conditions.”

Home Office, 2017

In March 2015 these centres held around 3,500 people (Bosworth in Shaw, 2016), and over the same year 32,400 in total came into immigration detention (Silverman & Hajela, 2016). Others may also be held at airports, ports of entry, and police and prison cells. For example, on 30 March 2015, 374 people, most of whom had completed a prison sentence, were held in prisons awaiting removal or transfer to an Immigration Removal Centre (Bosworth in Shaw, 2016). It is important to note that locations such as airports and ports of entry are outside of NHS England’s commissioning remit.

NHS England is responsible for commissioning all health care provision in that part of the Immigration Removal Centre (IRC) estate in England. As part of this responsibility, NHS England has developed a service specification template to take into account findings of this analysis and the recommendations of the Shaw Report.

The Shaw report, published in January 2016, had been commissioned by the Home Secretary, and made 64 recommendations. The report highlighted the poor state of detainees’ mental wellbeing. Many of the recommendations related indirectly to wellbeing. However, ten of the recommendations related directly to the wellbeing of detainees (recommendations 11,12,13,16, 23, 53, 55, 56, 57 & 58). In particular, recommendation 55 suggested that “...a clinical assessment of the level and nature of mental health concerns...” be undertaken (page 197: Shaw, 2016). This report is a response to the Shaw report’s recommendations, particularly to recommendation 55.

Chapter 9 and Appendix 5 of the Shaw report are devoted to the concerns relating to mental health. Appendix 5 of the Shaw report includes findings from a systematic review of international literature conducted by Professor Mary Bosworth, and examines the impact of detention on the mental health of detention immigrants. The Shaw report uses the term ‘mental wellbeing’, which covers a broad range of mental health problems, from diagnosable

mental illness to psychological and emotional distress that might fall below a clinical threshold. The Shaw report reveals that the manifestation of poor mental wellbeing amongst detainees is typically through symptoms of low mood and depression, anxiety and trauma. Serious mental illness, such as schizophrenia and bipolar affective disorders, are less common, but both Shaw and Centre for Mental Health's needs analysis encountered people in IRCs experiencing these problems.

Aims of the Mental Health Needs Analysis

This Centre for Mental Health review is intended to support NHS England and the Home Office in achieving Shaw's Recommendation 55. Centre for Mental Health was commissioned to:

- Provide a rapid needs analysis;
- Describe mental health need;
- Describe existing provision;
- Comment on relevant aspects of IRC regimes;
- Describe gaps in service;
- Make recommendations for improvement and to address gaps.

Whilst this review was mainly concerned with what happens within IRCs, the review's commissioners also asked the reviewers to comment on relevant issues that did not directly concern IRC regimes. These included the assessment of the vulnerability of people before arrival at an IRC and their continuity of care after leaving an IRC.

2. Mental health and detention

This section summarises the findings from the systematic review of the literature conducted by Professor Bosworth (see Shaw 2016, Appendix 5).

Professor Bosworth identified some 30 clinical studies, from Australia, the UK, Canada, the USA, France and Japan. The sample sizes of these studies ranged from 10 to 700. Most of the studies were Australian. She reports that Australia's detention regime is harsher than the UK and primarily operates to prevent asylum seekers from reaching Australian mainland. It is not uncommon in the UK for immigration detainees to have resided in the UK for many years before their detention. However, there are some similarities between Australia and the UK in that there is no upper limit on the duration of detention and detention has been outsourced to private contractors. For this reason some of the findings from Australian studies are believed by Bosworth to apply to the UK.

Bosworth reported some consistent findings across international studies:

- Immigration detention has a negative impact on mental health.
- The longer someone spends in detention, the more negative an impact it has upon their mental health.
- Depression, anxiety and post-traumatic stress disorder are the most common mental health problems.
- The causes of poor mental health are longer duration of detention, pre-existing trauma, pre-existing mental health or physical problems and poor health care provision.
- The worst outcomes are for victims of torture and women are a particularly vulnerable group.
- The negative impact on mental health persists long after detention.

The duration of detention and its association with poorer mental health outcomes are emphasised in Bosworth's review. However, studies vary in what they have found to be the point at which such a decline in mental health will be observed. One Australian study found the critical point to be 24 months; however,

most studies have found the critical point to come much earlier in detention with a range of 18 days to six months. The single UK study cited is that conducted by Robjant *et al* (2009). This was a pilot study including immigration detainees (n=67), other detainees (n=30) and asylum seekers in the community (n=49). Higher levels of anxiety, depression and PTSD were found in the detained immigrant sample and this was associated with longer duration of detention and/or a history of trauma. This study showed that the critical point for a negative impact on mental health was at 30 days.

Bosworth also made the link between physical health and mental health and whilst most detainees are young physically fit men, there are higher levels of illnesses such as diabetes and tuberculosis in the detainee population when compared to the general population, and longer term conditions are a risk factor for poor mental health.

As the systematic review focused on the impact of detention on mental health, it has little to say on the prevalence of mental health problems. However, a separate study conducted across four UK IRCs in 2009 found that four out of five detainees taking part in the study met a clinical threshold for depression (Bosworth and Kellezi, 2015).

“Those who were more depressed were: women, had health problems and were taking medication, had not lived long in the UK, had not been in prison prior to detention, had applied for asylum (up to 2 times), and/or had applied for judicial review. Those who were depressed had also specific experiences in that particular IRC: they were more likely to have participated in a fluid or food refusal, to have been placed on an ACDT [Assessment Care in Detention and Teamwork] plan, to have used interpreters, and to have been longer in detention. They did not use activities like the gym or religious services, did not report staff or the IT room or library as positive aspects of detention, and spent less time reading. They were also more likely to report that immigration detention was unjust.”

(Shaw report 2016, page 175).

3. Methods

The needs analysis employed a mixed methods approach and the individual elements are described below.

Using the literature to inform the review

We did not intend to repeat the work of Professor Bosworth, but rather use it to inform the review. It provided some useful ‘benchmarks’; for example, looking at whether there are systems in place in all IRCs for reviewing the mental wellbeing of detainees held for longer periods. The IRC estate has never undergone an exhaustive prevalence study such as that conducted in the English and Welsh prison estate in the mid to late 1990’s (Singleton *et al*, 1998). Singleton *et al*’s study adopted a methodology similar to that of the UK National Survey of Psychiatric Morbidity (see McManus *et al*, 2009) designed to establish the prevalence of mental health conditions in the community. We have used the findings from Professor Bosworth’s review as a guide to likely prevalence in the IRCs. Professor Bosworth’s findings are summarised in the previous chapter.

Interviews with key stakeholders and staff

Interviews were conducted with stakeholders and staff over the course of the review. The interviews were qualitative and semi-structured and followed a topic guide (see appendices). The topic guide was developed based on the literature and conversations with our commissioners. The topic guides were refined after the first few interviews were conducted. Two Centre for Mental Health staff conducted all the interviews. Those interviewed included:

- Managers and staff in IRCs;
- Managers and staff with health care roles in IRCs;
- Expert practitioners with experience of IRC and related settings;
- Those with a policy role for IRCs;
- Some key stakeholders from NGOs.

The interviews served a number of different purposes, in particular:

- Informing and refining the needs assessment itself (i.e. method);
- Providing qualitative evidence of needs and provision;
- Making and shaping recommendations that fit the IRC setting.

Review of existing data sources

This consisted of analysis of data already collected within IRCs, where these exist.

Collection data on the population

Centre for Mental Health developed a survey tool and issued this via email to all health care managers in each of the IRCs visited. The survey tool is given in the appendices. The survey provided a snapshot based on 30 March 2016 and sought details for all those detained on that day on length of stay, placement prior to the IRC (e.g. community, prison), numbers assessed under Rule 35 (parts 1, 2 and 3), and also the current waiting time for Rule 35 assessment, numbers on mental health caseloads, those awaiting transfer or assessment for transfer under the Mental Health Act, waiting times (from the point of referral), and for the previous 12 months the number of those transferred.

This data provided vital information of the context in which health care and mental health care is provided in IRCs.

Collecting data on provision

Data on mental health provision was sought from the IRCs and health care providers within the IRCs. This included all relevant health services, psychological interventions and counselling and other sources of provision (such as those provided by NGOs). In all cases this data was collected through interviews with health care managers and lead mental health staff on visits to the IRCs. There is also some additional information on newly contracted services by the local NHS England commissioner.

Assessment of need within a sample of people detained in IRCs and enrolled in mental health provision

Centre for Mental Health asked that mental health staff completed a Health of the Nation Outcome Scale (HoNOS) rating for 15-20 individuals at each IRC. For the purposes of this exercise the two IRCs at Gatwick were treated as one unit, and likewise at Heathrow, so as not to overburden the mental health staff, who worked across both sites. The sample comprised of individuals who had been assessed by mental health care staff.

The Health of the Nation Outcome Scale (HoNOS) is widely used as a routine measure of patient outcomes in NHS Mental Health Services. It is a 12 item scale, completed by staff, that largely focuses on clinical symptoms, but does have items on relationships, daily living skills and activities. Each of the 12 items on HoNOS can be rated as 0 for ‘no problem’, 1 for a ‘mild problem requiring no action’, 2 for a ‘minor problem but definitely present’, 3 for a ‘moderately severe problem’ or 4 for a ‘severe to very severe problem’, resulting in a possible total score of 48.

It can be used across the range of diagnostic conditions and provides a proxy for severity of need. The HoNOS is short and easy to use, familiar to most mental health practitioners and requires little or no training to deploy. The mental health needs analysis was not resourced to conduct full clinical interviews or to provide training to mental health practitioners in the use of unfamiliar measures.

Interviews and groups with detainees

We attempted to interview 10 detainees from each of the IRCs visited. The interviews were qualitative and semi-structured. These had a topic guide (see appendices) and were developed by reviewing the literature and conversations with commissioners, with some refinement after the first few interviews were

completed. Two Centre for Mental Health staff conducted all the interviews.

As before, the two IRCs at Gatwick were treated as one unit, and likewise at Heathrow. This meant that the target number of detainees interviewed would be 50. A total of 32 detainees (64% of the target) were interviewed. Most of these were via one-to-one interview, though some were interviewed as a group. The individuals were questioned about:

- Their experience of detention in an IRC;
- Their wellbeing;
- Their lives prior to being detained;
- What they perceived as being their mental wellbeing needs;
- How these mental wellbeing needs were being met;
- Their views on health and mental health care services;
- Their thoughts on supporting wellbeing.

Observation of process and practice

Centre for Mental Health visited the establishments between 2-3 times and viewed processes relating to health; for example, health consultations and reviews. The visits also included speaking with relevant staff, managers and residents. Each initial visit followed a standard format and this included:

- A tour of the health care units;
- A tour of the IRC, including facilities for detainee activity and employment, chaplaincy and welfare services and the Care and Separation ('segregation') units.
- A fact-finding interview with health care and/or mental health care managers, seeking similar information to that of the survey (see appendices), but also detail of health care and mental health care provision, views on mental health need, Rule 35 assessments, views on gaps in service and challenges to provision with each IRC.

Most visits were conducted by a single member of Centre for Mental Health needs analysis team. However, the first visit to the Heathrow estate was conducted by both members of the team to ensure consistency of approach.

Limitations of the methodology used in the review

We were commissioned to provide a rapid analysis and this posed challenges both for Centre for Mental Health and for the health and mental health services within the IRCs. These are small teams and our review added to the competing demands made of them.

The detainees we spoke to and those we received ratings on were chosen for us by health and mental health care staff and we cannot be sure how representative their views are, and if we have therefore missed some important views or picture of need. However, across those IRCs we visited, and those detained therein who we spoke to, there was consistency in what was being reported. Several interviews were conducted with non-proficient English speakers using available translation services, though one attempt to speak with a non-English speaker at Yarl's Wood was aborted due to the translation telephone equipment not being available at the time.

The target for interviews with detainees was relatively small (n=50) as was the number of interviews actually achieved (n=32), given

that the IRCs visited can hold up to 2,654 individuals (and most held close to maximum capacity). The interviews aimed to gain insight and understanding of detainee experience, seeking to include a diverse sample in terms of age, ethnicity, gender and reason for detention. However, the small sample size does create challenges for generalising the findings. At best, the interviews give a "flavour" of detainee experience but this may not be the complete picture. To address this limitation, we have employed a mixed methodology, increasing confidence in findings if they are triangulated (where different methods of data collection result in similar findings).

There is a significant amount of missing data in the surveys completed for the review at each centre. This means we have not been able to report some of the details of the mental health services. In both the survey data and clinical assessment tool (HoNOS) there is significant variability across centres. This may be due to genuine variance in the wellbeing of detainees across centres. However, it may also be due to variance in the way problems are interpreted and reported. For example, the "problems with living conditions" item on HoNOS was recorded as either 'no problem' or a 'mild problem', which conflicted with detainee views who saw their detention and therefore their 'living conditions' as being a major problem and one (combined with the uncertainty of their detention) that affected their mental wellbeing.

4. Description of the IRCs

The English IRCs/holding centres included in the review are:

- The Verne IRC in Dorset
- Pennine House Short Term Holding Facility in Greater Manchester
- Morton Hall IRC in Lincolnshire
- Yarl's Wood IRC in Bedfordshire
- Campsfield House IRC in Oxfordshire
- Brook House IRC at Gatwick Airport in Sussex
- Tinsley House IRC at Gatwick Airport in Sussex
- Heathrow IRCs (comprising of Harmondsworth and Colnbrook) at Heathrow Airport in London

The centres vary in size, regime and design. For example, Harmondsworth is purpose built, has a maximum capacity of 600, is built to category B prison security standards and has a more restricted regime than that of Campsfield House, which holds a maximum of 282 detainees, who have free range to move around the centre throughout the day, on what was the site of a former Borstal and women's prison.

People who are detained in IRCs come from a number of sources; some may be very recent arrivals in the UK and have come via a period in police custody. Some may have lived in the community and been detained by police or Immigration Enforcement personnel. Yet others may be former prisoners. With regards to the latter group, any foreign national receiving a sentence of 12 months or more is considered for removal, and courts can also make such a recommendation when sentencing.

Figure 1 gives an overview of capacity, turnover, whether the IRC holds men or women and lengths of stay based on the survey (see overleaf).

It illustrates the significant level of movement, with a considerable number of detainees staying less than a month and all IRCs turning over the equivalent of, or more than, their static population each month. This clearly creates pressures on health care services based within these establishments. However, there is also a significant population within each IRC that have stays in excess of this and over the period that the only UK based study indicates risk of increased deterioration in mental wellbeing (see chapter 7).

Figure 1: Overview of the IRCs

	Max. number of detainees*	Turnover per month**	Gender	Length of stay: number of detainees residing at centre on 3/3/16 in weeks/ months:				
				12 mths	6-11 mths	2-5 mths	1 mth	2 wks or less
<i>Percentages rounded to total 100%</i>								
Gatwick								
Brook House	448 (322 on census day)	750-1000 (Gatwick estate)	Men	3 (1%)	31 (9.5%)	151 (47%)	119 (37%)	18 (6.5%)
Tinsley House	119 (plus 34 family beds)			Data not provided				
Cedars	3 (now 2) families		Families	Data not provided				
Heathrow (data provided on whole estate rather than by its two IRCs)	1,067 (934 on census day)	No data on Heathrow estate		No data	39 (4%)	470 (50%)	196 (21%)	229 (25%)
Harmonds-worth	676		Men	Data provided for whole of Heathrow estate (see above)				
Colnbrook	391		Majority men	Data provided for whole of Heathrow estate (see above)				
Morton Hall	392 (302 on census day)	340-360	Men	***6 (2%)	***21 (7%)	***47 (16%)	***95 (31%)	***133 (44%)
Yarl's Wood	410	450-550	Majority women	Data not provided				
Campsfield House	282 (256 on census day)	300	Men	0 (0%)	4 (2%)	34 (13%)	88 (34%)	130 (51%)
The Verne	580 average	467 (new) 468 (discharged)	Men	1%	2%	10%	36%	51%
Pennine House	32 (HMIP 2016)	No data on turnover, but stays tend to be for less than a week	75% (HMIP 2016)	0%	0%	0%	0%	100% a week or less (HMIP 2016)

The above data was provided/coordinated by health care managers

*: this is capacity and though some were close to capacity, none of the IRCs were full. Yarl's Wood was in quarantine throughout the review and was not taking new admissions.

** : these are based on estimates given on the first visit, each IRC has been asked to confirm and this is outstanding.

***: Morton Hall data refers to the 7 days before 8/4/16 as this was the data they had available.

5. The review findings

Mental wellbeing

Health of the Nation Outcome Scale (HoNOS)

The HoNOS was returned completed by four IRCs. The Verne was subject to a health needs assessment at the time of this review and was not asked to submit HoNOS, and Morton Hall was not able to complete this data in time for the review. The IRCs at Gatwick and Heathrow were allowed to submit one set of HoNOS each that could be based on caseloads from one or both of the IRCs on each site. Figure 2 shows the details of the sample of the HoNOS completed at each site. The HoNOS was completed for a total of 35 participants. The total average score varied across centres (see Figure 2).

The average score at Yarl’s Wood, 19.85, was markedly high. This may reflect differences in HoNOS scoring, but is likely to reflect higher levels of distress at Yarl’s Wood. The scores presented by most of the IRCs are remarkably low, and do not correspond with our qualitative data from detainees and staff. The majority of our data indicated that levels of distress, problems with living conditions and daily activities and lack of both certainty and liberty

had a significant impact on the wellbeing of those detained.

Across IRCs, the most commonly reported problem was “depressed mood”. At Yarl’s Wood the most commonly reported problems alongside depressed mood were “non-accidental self-injury”, “other mental and behavioural problems”, “relationship problems” and “living conditions”.

Across all other centres, the most severe problem reported was “problems with hallucinations or delusions”. At Gatwick and Heathrow, one individual was reported as having a moderate problem relating to hallucinations or delusions. At Yarl’s Wood, 11 individuals were reported as having at least one severe problem relating to the following items:

- Overactive, aggressive, disruptive or agitated behaviour;
- Non-accidental self-injury;
- Cognitive problems;
- Problems with hallucinations or delusions;
- Problems with depressed mood;
- Problems with relationships.

Figure 2: HoNOS sample characteristics

	Gatwick (Brook House)	Campsfield House	Heathrow	Yarl's Wood
Number	20	10	5	20
Gender	Male	Male	Male	Female
Age	32 (21-56)	31.9 (19-43)	36 (25-52)	35.5 (20-62)
Length of stay	Average 2 ½ months (2 weeks – 10 months)	Average just under 2 months (1-4 months)	Average 1.5 months (3 weeks-3 months)	Average 1 month (2 days – 3 months)
Number transferred from prison	5	3	0	5
Detained from community	7	3	5	15
Detained from the airport	1	0	0	0
Transferred from hospital	1	0	0	0
Detained from a police cell	1	0	0	0
Transferred from another IRC	3	4	0	0
Assessed under Rule 35	4	3	3	7
Average Total HoNOS Score	2.1	2.1	4.4	19.85

Broadly speaking, our findings were similar to the Shaw report in terms of known mental health and wellbeing needs. Most referrals to mental health services were made in relation to depression, anxiety, sleep problems and trauma. Across the IRCs, there is a small group of people experiencing severe mental health problems, including various forms of psychotic illnesses. Some of those with such diagnoses were well maintained through medication and regular care reviews. Despite people with severe and enduring mental illness being a relatively small part of the detainee population (NHSE 2015 reports that less than 6% of the population have serious mental illness) they occupy a lot of staff time and resources, particularly so when they require transfer under the Mental Health Act. During the course of the review we met individuals who did not appear to be well enough to be living in detention (e.g. appearing floridly psychotic and paranoid). Nurses discussed assessing individuals as “unfit for detention” but that these assessments were on occasion being overruled by Immigration Enforcement.

Trauma experiences

The majority of detainees interviewed discussed experiencing some form of trauma in their life before being detained. For example, some had experienced fleeing a country where their religion, ethnic group or sexuality was being persecuted; witnessing their family and friends being killed; being a victim of domestic violence, sex trafficking or female genital mutilation (FGM); and fleeing a death sentence because of their sexuality. They talked about the cumulative effects of a traumatic event on their mental wellbeing, for example:

“...I was a child when I moved to the UK and now I’m nearly 40. Whilst I was here my very close family member died. I became depressed and started drinking. Then I lost my job, my home and was homeless. I started getting into fights, at one point I was sectioned because I thought about killing myself. Then I got convicted for fighting and ended up here...”

“I left [my country] because I was bisexual and my relatives wanted to kill me. I lost my parents when I was young...if they were still here I don’t think I’d be in this state. My partner was murdered and I fled, I met this person who said they could help me but they actually sold me into the sex industry. I was trafficked to Europe... I was tortured, raped and had no access to medical [help]... when I reached the UK I fled these people and then I was on the streets...”

“...these are papers saying my family are wanted for being Christian and we are breaking the law so we will be beheaded. On this letter, those are my children’s names and my wife’s... but my asylum case has been refused... I’m trying to stay strong but I can’t...”

Interviewees discussed experiencing heightened symptoms of trauma since being in detention, such as flashbacks, intrusive thoughts (e.g. family being killed at home), suicidal thoughts, nightmares and problems sleeping.

Talking about trauma was difficult and the fact that this might be required for purposes of applying to remain in the UK or for appeals against decisions to remove did not make this any easier. One young man stated:

“...you can see that things have happened to me [he pointed to visible scarring on his person]...and I can tell you I was hit with bars and knives...I can say that my family members were killed and that my sister was raped, but if I was to say more...give more detail... then I have to think about it and [it] comes back to me and I can’t get it out of my head...I would not be able to function this afternoon...”

Another reported:

“...I was given indefinite leave to remain years ago, before I went to prison... now they are asking me to tell them all this again...I had started to put it behind me...they know all this stuff about me and they are making me say it again...”

Hidden needs relating to mental wellbeing

Staff discussed lesser known needs, such as hidden acquired head injuries, learning disabilities and difficulties, and Autism Spectrum disorders. Staff in all IRCs acknowledged that screening and assessing for such vulnerabilities was negligible. Across centres, we met a number of detainees who had physical symptoms, such as chronic headaches and migraines, back pain, stomach ache, seizures and respiratory problems, which they felt were linked to their anxiety and distress. General practitioners and staff recognised that it was possible that many physical complaints might be related to the psychological state of detainees. However, there did not seem to be any process in place to routinely review mental wellbeing for such cases.

Stigma

Both detainees and staff also discussed stigma, mental health and use of mental health services, particularly in some cultures. They discussed how commonly used mental health language in English, such as depression and anxiety, may not translate very well. Therefore the language used or way in which someone manifests distress may be different.

An emphasis on mental wellbeing

Key to our understanding of the needs of an individual (and therefore the intervention required) is that every person in detention faces some challenge to their mental wellbeing and experiences psychological and emotional distress. They may or may not reach a clinical threshold but the distress they experience is still disabling and can be life-threatening. Centre for Mental Health met individuals on

Assessment Care in Detention and Teamwork (ACDT), the IRC system for managing vulnerable detainees, particularly those at risk of suicide and self-harm. ACDT is similar to Assessment Care in Custody and Teamwork (ACCT), the prison system for managing suicide and self-harm risk. ACDT is multidisciplinary and involves health care as well as other IRC departments. The individuals we met reported having no history of mental health problems. However, they described feeling extremely distressed and suicidal because of what was happening to them in terms of uncertainty, “loss of freedom”, isolation, and fear of being returned to a country where they believed they would be killed:

“I don’t feel as if I have anything to live for... I have lost everything...”

Life in detention was described as “traumatising” and one which exacerbates distress. A focus on mental wellbeing would include severe mental illness as well as addressing the broader psychological distress detainees were experiencing:

“Here there are some people with existing mental health problems and being here makes it worse... then there is everyone else, people with no mental health problem but being here creates so many emotional problems... we need to think of it as a spectrum, where the overwhelming emotions can lead to mental health problems...”
(Mental health practitioner)

Another mental health practitioner stated:

“...I don’t think you can underplay the importance of being listened to for detainees, they need opportunities to vent and feel heard...it’s important to their wellbeing...”

6. Impact of detention on mental wellbeing

A key point relating to wellbeing for this population is the impact that detention has on their vulnerability. Participants described the centre as “hell”, “mental torture” and “like a prison...a fortress”, and staff observed how people’s wellbeing deteriorated in detention.

Detainees reported that the loss of liberty and being part of a prison-like regime posed challenges to mental wellbeing. For example, being locked up from 9pm for the night, having no control over their room-mate, and restricting their ability to be meaningfully occupied. Detainees discussed how specific aspects of the environment, like the locks and no fresh air, made it feel “suffocating” and like “captivity”. It should be noted that regimes and ‘lock down’ varied across the IRCs and sometimes within an IRC. Campsfield House was generally acknowledged by staff and detainees to have the least restrictive regime for men (Yarl’s Wood appears to operate a relatively unrestricted regime for women).

The level of uncertainty about their future, compounded by poor communication, contributed to poor mental wellbeing. ‘Uncertainty’ featured prominently in the accounts of detainee distress, for example:

*“...I just want a f*****g decision...there is a war back there [in his country of origin] so they won’t be removing me, but they won’t make a decision either way... [it] just brings me down...”*

“...I don’t sleep with worry...I can’t focus on doing things...I don’t know what is going to happen...”

“You just don’t know what’s going to happen to you... only your freedom will change this... that is the only way to relieve stress...”

“I am very scared by the people who’ve been here for a long time [starts crying]...one month is okay, but a long time is very scary... I can’t sleep, my mind is going crazy at night time...”

The confusion around the legal procedures “caused a huge amount of distress to detainees”. Solicitors commented on how frequently the law changed, making the process increasingly confusing for detainees. Detainees discussed how much stress the legal procedures caused and often felt there was no one they could ask for help. They discussed the long waits between communication from the Home Office and how often the Immigration Enforcement officers in the centre were not able to help. Mental health staff discussed how they felt “clueless” and powerless to offer emotional support around detainees’ cases. In some centres, detainees described how they were discouraged from mentioning their legal case in their therapy sessions, even though they felt the need to vent. As can be seen in some cases it clearly impacts upon their mental wellbeing. Offering both practical support (i.e. helping them to make a call to their solicitor) and emotional support (i.e. acknowledging their distress) in these sessions may help to alleviate some of the distress.

The lack of social integration amongst detainees in IRCs due to the transient and distressed nature of the population led to detainees feeling isolated:

“I feel really scared, alone and suffocated... In the community I had friends but here there is no one...”

Some detainees discussed how they felt more integrated with other inmates in prison because there were initiatives, like prison councils, which provided opportunity for socialising and building a community. However, at the IRC these detainees described feeling much more alone:

“At prison I was integrated into the system and was focused. I had a job in the laundry place and a role at the prison council so that uplifted my spirit. Here I spend more time on my own with nothing to do...the problem is everyone is in the same boat and everyone is in their own world, thinking about their own stress, so there’s not much integration...there isn’t anyone to talk to in the centre. Like my roommate is in a different world...”

Detention was described as re-traumatising for some people:

“...being here is reliving my trauma because it feels like the captivity I experienced when I was a sex slave...”

“Through the immigration process I’m having to relive sections of my life that I’m trying to forget... things I’ve buried deep inside I’m having to share and now I’m reliving my past. But I don’t feel as if I get any support for this...”

In addition, the point and manner in which some people were detained was described as traumatising. This appeared to be the case particularly for those we spoke to who had been in the community prior to detention. Some reported early morning “raids” and men and women in uniform entering their place of residence.

“...I have never committed a crime and they took me like that and left me in a police cell...”

Some reported arriving at an office where they were required to routinely report and then being “seized” without forewarning.

Several of the people we spoke to had been in prison prior to their detention and they contrasted the experience. The following is a typical account:

“...you’ve done something wrong, so they put you away...rightly...and you do your time. I did all the courses, I worked on changing and turning my life around...I did change and they saw I had changed...you can earn early release...you know what’s happening and it’s fair...”

He continued:

“...but here...well, there are no answers...I speak to my caseworker...I don’t get anywhere...I am just stuck...”

Some detainees mentioned being told on the day their prison sentence ended that they were going to be moved to an IRC.

7. Services in place across the IRCs

This section provides an overview of the services currently in place across each IRC and then discusses examples of good practice.

Figure 3 provides an overview of mental health assessments and interventions in the IRCs over seven days.

Figure 3: Numbers of assessments and interventions in IRCs over 7 days

	Morton Hall	Campsfield House	Gatwick	Heathrow	Yarl's Wood
Number of mental health assessments	6	3	52	10	9
Number of medication reviews	2	10	3		14
Number of care reviews	3	Missing data	52	10	32
Number of one-to-one psychological interventions	2 (psychological intervention)	2 (counselling)	0	0	0
Number of group psychological interventions	0	0	0	0	24
Number of individuals attended another type of intervention	Missing data	Missing data	N/A	4	
Number of detainees who have received onward referral for a mental health or related vulnerability	Missing data	Missing data	4	25	2
Number of unattended appointments ('Did Not Attend' - DNAs)	5	N/A	50	0	5
Number of detainees treated with medication for depression	NK	3	11	65	11
Number of detainees treated with medication for anxiety or stress	NK	6	2	15	6
Number of detainees treated with anti-psychotic medication	NK	1	1	16	3
Number of detainees treated with sleep medication	NK	7	2	27	4
Number of detainees assessed under Rule 35	Missing data	11	7	43	10
Number of detainees on an active ACDT	Missing data	6	7	48	0

Figure 3 shows some apparent and marked differences in statistics reported by each IRC for the census date upon which the survey was based (on 31 March, 2016 or in the period leading up to it). Most notable are the high volume of assessments at Gatwick, the higher rate of unattended appointments also on the Gatwick estate, the large volume of detainees on

ACDT at Campsfield House, and that there are no reported ACDT cases at Yarl's Wood on the same day. Additionally, Heathrow has notably high numbers of detainees being treated with medication for depression or sleep problems. In addition, the rate of DNAs at Heathrow is surprisingly low. One possible explanation is the outreach approach of the mental health

nurses at Heathrow who deliberately spent a lot of time on the wings working to ensure high patient engagement. Campsfield House has arguably the most relaxed regime of the IRCs visited as part of the needs analysis and has the smallest population, and Yarl’s Wood re-ported the highest levels of distress (for example, see the HoNOS scores in chapter 5). There may be some error in the reporting as some numbers are markedly higher or lower than expected.

Heathrow

The Central and North West London NHS Foundation Trust is the health and mental health care provider at both Heathrow sites and runs as a single service. Heathrow’s IRCs are Harmondsworth and Colnbrook. The mental health team comprises of a psychiatrist who visits for half a day a week, Registered Mental Health Nurses (RMNs), a substance misuse nurse and part-time consultant, an engagement officer and GP’s. One of the nurses is a psychological intervention specialist and another is being recruited to this role.

The service provided generally consists of an initial assessment and follow-up care reviews. Predominantly the work is medication management as well as psychoeducation, developing coping strategies and containing distress. To address PTSD and complex trauma there are up to six sessions focusing on trauma. Improving Access to Psychological Therapies (IAPT) is being introduced to address low level mental health issues, such as sleep and anxiety. Additionally, the chaplaincy team play an important role in providing culturally sensitive support.

Gatwick

Gatwick consists of Brook House IRC and Tinsley House IRC. G4S provide the embedded primary health and mental health care teams, and these consist of Registered Mental Health Nurses (RMNs) and Registered General Nurses (RGNs). RMNs provide a dedicated mental health function. There are currently three RMNs in post; one of those is a senior RMN. The position for a fourth RMN has recently been filled.

RAPT (Rehabilitation for Addicted Prisoners Trust – a voluntary sector provider) will be providing a substance misuse service and are currently planning their service at Gatwick. Sussex Partnership NHS Foundation Trust provides the consultant psychiatrist, and two occupational therapists who run a weekly group. The consultant psychiatrist is there half a day per week and has appointments slots for four clients (two reviews and two new assessments). Hospital beds are also provided through the Sussex Partnership NHS Foundation Trust.

The service consists of initial assessments and follow-up care reviews delivered by the RMNs. There is a weekly emotional wellbeing group, which uses a one-contact approach focusing on listening to detainees’ distress and building their resilience and coping strategies. The welfare team and chaplaincy are seen as key in promoting wellbeing and addressing vulnerability, and collaborative work between the teams takes place. For example, the chaplaincy team is involved in ACDT reviews.

Morton Hall

Currently the team comprises of a clinical matron for mental health (who is also the learning disability lead), two agency RMNs, one clinical psychologist for one day per week and one consultant psychiatrist for one session per week. The health care service is provided by Nottingham Health care NHS Foundation Trust.

The mental health team conduct initial assessments and follow-up reviews. Morton Hall has been introducing a stepped care model, which skills up the whole estate to be able to provide support. They have introduced various vehicles for assessment, including a suicide interview, a suicidal ideation interview and a risk assessment mental health form. The psychologist provides ongoing one-to-one psychological intervention. This includes trauma-focused therapy, which is tailored to the time-frame of the individual. Approaches include narrative therapy, but also symptom management and relaxation techniques. The psychologist is running mental health awareness training for all staff across the estate.

Campsfield House

Campsfield House's health care services are now provided for by Care UK and this change occurred during the review on 1 April 2016.

At least four of Campsfield House's six permanent nursing staff has a mental health qualification (RMN), either as a sole or dual qualification. One of the RMNs is also the senior or lead nurse. There are six additional regular bank staff and some of these may also be RMNs. The nursing function at Campsfield House is a generic nursing function, with at least one RMN on shift having responsibility for conducting mental health assessments and then making decisions on referral (typically to the GP, secondary care or the sessional counsellor). At the time of the visits, Campsfield House had some sessions from an Oxford-based secondary mental health care service.

It was predicted that the nature of the mental health care offer would change and that psychological care would become more available.

At the time of visits a counsellor offered two sessions per month for one-to-one counselling. It was not possible to speak to the counsellor and learn more about this service.

Yarl's Wood

There is currently one senior RMN, one full-time RMN and an agency RMN (a third permanent full time equivalent RMN is being recruited). The psychiatrist attends once a week. There is a nursing assistant who, at the time of the survey, provided a wellbeing service. A charity, Kaleidoscope Plus Group, has been commissioned on a two-year pilot basis to provide psychological interventions. At the time of the need analysis and drafting of this report, they were recruiting a full time IAPT psychological wellbeing practitioner.

The bulk of the RMNs' work is initial assessments and follow-up reviews. The wellbeing group is provided Monday to Friday

and sees approximately eight service users per day, in both one-to-one and group sessions. This uses a range of approaches such as talking therapies and relaxation techniques (for example, massages, relaxation tapes and reflexology). Yarl's Wood also has a weekly session of psychiatry provided by SEPT (NHS Trust). NHSE had made the offer of some small grant funding to three groups who offer listening services at Yarl's Wood.

The following two IRCs were not visited as part of Centre for Mental Health's mental health needs analysis. In each case the most recent health needs assessment (HNA) findings are summarised here.

The Verne - Health care provision and summary of evidence on mental wellbeing

The decision not to visit the Verne was made as it was subject to a Health Needs Assessment (HNA) at the time of the mental health needs analysis and it was agreed to use the pertinent findings from the former (Lewis & Meek, 2016) to inform the latter.

The HNA looked at all aspects of health care at the IRC. Like all IRCs it had a significant turnover, averaging 474 detainees at any point but a similar number pass through the IRC each month. Mental health provision was offered through a stepped care model. The mental health services offered an integrated approach (i.e. primary and secondary mental health care were merged within a single team). It was reported that 14.3% of the population had been referred to the mental health service; this amounted to an average referral rate of 63 per month.

The HNA reports the average prevalence rates as:

Depression	6.9%
Psychoses	4.0%
Other problem	7.2%

The authors of the report suggest that these are likely to be underestimates of need, but that detainees may seek help for emotional problems from their peers or staff outside the mental health service.

It was also reported that 3% of new detainees (over a six month period) were assessed to be victims of torture. ACDT had been implemented 128 times in the same period with 23 recorded incidents of self-harm equating to four such incidents per month.

The report outlined details of the mental health provision. Like other IRCs, The Verne offered physical health care 24 hours a day and seven days a week. However, mental health services operated Monday-Friday in office hours. An integrated mental health team was provided by Dorset Health Care University Foundation Trust and comprised of one whole time equivalent (WTE) in-house primary care mental health worker, one 0.5 WTE health care assistant and one WTE secondary care mental health worker. The integrated team comprised of a prison mental health lead, five community mental health workers, three primary care mental health workers, two assistant psychologists, two mental health support workers, one consultant psychiatrist, one clinical psychologist, one chartered psychologist, one doctor specialising in adult psychiatry and access to the Learning Disability (LD) intensive support team. There was no mental health team over the weekend and primary health care covered provision. Secondary mental health intervention included medication monitoring, one-to-one psychological therapy and coordination

of mental health transfers. There was no counselling service at The Verne.

Clinicians from The Verne took part in a Department of Health funded national consultation on the interface between mental health and criminal justice, conducted by Centre for Mental Health in February 2015. At this time it was reported that transfers under the Mental Health Act had tripled since it had ‘re-rolled’ as an IRC from a category C prison in 2014. Clinicians reported that in their view the levels of severe mental illness had been high and the need for transfer under the Mental Health Act was higher than one would expect for a busy local prison (see page 28, Durcan, 2016). The HNA reported that in the six months prior to its completion, one transfer under the Mental Health Act had taken place. This suggests that something has changed in the population that The Verne receives, and the rate of transfer is much reduced.

Pennine House - Health care provision and summary of evidence on mental wellbeing

Pennine House is a short term holding facility with detainees often staying one or two days. It was decided that it would not be visited and that the most recent HNA would be used (Cairns *et al* , 2015). This was published in February 2015 and changes may have occurred in the meantime. In addition, the most recent inspection report by Her Majesty’s Chief Inspector of Prisons was referred to (HMIP 2016). The Inspectorate’s report, conducted

in January 2016, reported that 16 people were detained there, 12 men and four women. The average length of stay was 37 hours and 51 minutes; with the longest detention at the time being seven days (records for a longer period indicate the longest period of stay had been 12 days). Most detainees were independent travelers whose ages ranged 18-70 (average 32 years). A concern for the Inspectorate was that men and women shared facilities. This report, based on an unannounced visit, was largely positive and reported that recommendations from the previous visit (in 2013) had been achieved with exception of men and women having separate facilities, greater access to the internet particularly for legitimate communication and accessing information, and the relocation of the visiting facilities (currently held in the reception area and sometimes during receptions). Obviously in the context of this mental health needs analysis such issues have a potential influence on wellbeing.

Cairns and colleagues (2015) reported that the health care team comprised of nurses with access to an on-call doctor, although this was reported as used rarely at the time. The team had two full time nurses and four nurses working 24 hours each per week (plus regular bank staff) and provided 24/7 care - one nurse being present at night. At the time of the HNA, three of the staff had both mental health and general nursing qualifications, though it was unclear what this meant in terms of mental health trained nurse coverage.

The primary concern with regards to mental wellbeing was reported as risk of self-harm and

suicide, though of the 4.3% of detainees over a four-month period who reported a history of previous self-harm less than 1% of detainees over this period were felt to pose a risk on admission to Pennine House. Cairns thought this may be an underestimate of the likely detainees posing a risk of suicide attempts and self-harm. This was based on comparison with data on women prisoners and prisoners more generally, and known risk in these populations (12% of detainees at Pennine House were women and approximately 25% were former prisoners). However, Centre for Mental Health interviews with clinicians across the IRCs visited suggested that IRC detainees have a very different profile to prisoners and also that this applies to former prisoners (i.e. they as a group do not have the same profile as a prison population).

Over a four-month period only 6.5% of the population had previous known history of poor mental health and/or mental health service use. Once again less than 1% was deemed to have a current mental health need. In the previous 12 months, one detainee had been transferred under the Mental Health Act. Cairns *et al.* (2015) reported that little more than screening and assessment can be offered by health care at Pennine House due to the rapid turnover of population. Cairns and colleagues (2015) were concerned about how isolated the health care team was (Centre for Mental Health also had this concern over the health care teams it visited). Cairns and colleagues (2015) recommended closer working links with peers at HMP Style, which is relatively close.

8. Good, promising and well received practice

There were examples of good or promising practice in all of the IRCs visited. This section describes some of these and particularly those that detainees raised in interviews.

Across the centres we observed and were told by detainees about members of dedicated health care staff providing fantastic care and support.

Registered Mental Health Nurses (RMNs) across all the centres were described as helpful in the way they listened to detainees, and that they helped contain their distress and build coping strategies whilst in detention. One interviewee discussed how he found the nurses very supportive in exploring his trauma with him. Detainees talked about the importance of staff who acknowledged and checked in with them in passing. There were examples across centres of individual staff members going on to wings and doing outreach work to engage their patients. Detainees discussed how staff encouraged them to participate in activities and education, which they felt helped them to manage their stress. All of those spoken to at Campsfield House spoke positively about health care provision in general and were impressed by how accessible it was.

Psychological interventions

It was generally recognised by all the mental health providers Centre for Mental Health spoke to that the greatest need across the IRC estate was for psychological and talking interventions. The services at the Heathrow IRCs and Morton Hall appeared to have made greater progress in achieving this, having psychological practitioners in post. Such a service has been commissioned for Yarl's Wood and an IAPT practitioner was being recruited by the new provider at the time of the needs analysis. A stepped care model is outlined as the mental health delivery model in the NHS England specification across the IRCs. Stepped care models seek to treat people at the lowest tier possible and the patient is only 'stepped up' into higher levels of professional support as needs be. The lower tiers might include interventions that maintain

wellbeing and promote health, followed by self-help and guided self-help interventions, before climbing to more formal short term and then longer term treatment offers. Stepped care models are seen as potentially offering efficiencies in psychological interventions (e.g. Bower & Gilbody, 2005). The extent to which a stepped care model had been operationalised varied across centres. All centres visited had interventions targeted at different tiers of the stepped care model, for example, short-term interventions to develop coping strategies and group wellbeing sessions. Staff discussed barriers to full implementation of a stepped care model as outlined by NICE (2011). For example, staff discussed only having psychiatrists and clinical psychologists in once a week to deliver higher tiered work. They also highlighted the skill required by officers to be able to provide the lower-tiered work that would be provided by "equivalents in the community...e.g. general nurses, families, schools". Morton Hall has arguably made the most progress in developing its plan for a psychological therapy offer and in developing a stepped care model of mental wellbeing service delivery. At Morton Hall, as well as short-term higher-tiered interventions for trauma (e.g. EMDR and Narrative Trauma Therapy) there was an emphasis on lower level tiered work, for example, the clinical psychologist was delivering extensive mental health training to staff across the estate (i.e. officers, Home Office staff) to support them to understand and identify mental health needs and to have more psychologically informed conversations with detainees. This was seen as important in being able to deliver a stepped model of care as all staff would be equipped to address the wellbeing needs of the detainees at the lower-level tiers.

All centres discussed adapting psychological interventions to suit a one-contact approach (some detainees will be in an IRC for only a very brief period and may have just one opportunity for mental wellbeing support). A one-contact approach works on the assumption that assessment and intervention may have to take place in the same session, due to the

rapid turnover of detainees and therefore the undefined and potentially short duration of detention. Of particular significance is the work being done at Morton Hall in tailoring the intervention to the time available. Once a detainee has been referred to mental health, the team contacts the Home Office to find out where the detainee is up to in their detention process. This gives them a very rough estimate of how long they might have with them and helps shape the 'offer'; for example, if someone is at the beginning of the process and is going to put in an appeal, the team know they have a while to work with that person. If the detainee has exhausted all appeals and a flight has been booked, they know they may only have a couple of sessions. In this instance, the intention of the sessions would be to help them develop coping mechanisms that they take away with them. Of course the time is subject to change, but it does mean that the team are making the most of the time they have to provide an effective and safe intervention.

Psychologically informed approaches also tend to use psychological formulations to understand the wellbeing or otherwise of an individual. These take the forms of narrative descriptions of the person and their problems and the context in which both sit. Such formulations inform interventions and the narrative changes as the person does. It struck Centre for Mental Health as a particularly useful way for mental health services to understand the need of a detainee.

Wellbeing sessions (Yarl's Wood)

Yarl's Wood ran daily one-to-one and group wellbeing sessions, which included talking therapies, relaxation, massages, meditation and reflexology. Whilst the evidence base for what the wellbeing service offers is limited, it was well received and highly regarded by the detainees we spoke to, who stated it provided a relaxing space and one where they could vent and alleviate stress and tension. This was seen by detainees we interviewed as very important in relieving immediate stress and developing coping skills: "I find the massages and having someone to talk to calming". It was accessed by many detainees with varying mental wellbeing problems, including patients who were experiencing psychosis.

Psychological Formulations

These can be described as having the following characteristics:

- A summary of the service user's core problems;
- A suggestion of how the service user's difficulties may relate to one another, by drawing on psychological theories and principles;
- The aim to explain, on the basis of psychological theory, the development and maintenance of the service user's difficulties, at this time and in these situations;
- Indication of a plan of intervention which is based on the psychological processes and principles already identified;
- Being open to revision and re-formulation.

(Johnstone & Allen 2006, cited in British Psychological Society (BPS) 2011, p. 6)

Formulations are an attempt to understand an individual in their context, and to do so using 'plausible account' (Butler, 1998 cited in BPS, 2011) in the form of a shared narrative rather than a categorical diagnosis. The formulation provides a hypothesis to be tested and its narrative changes as the individual does.

(Taken from Durcan, 2016)

Trauma focus

Morton Hall, as part of its psychological intervention offer, was also developing approaches to working with people who have experienced trauma. They discussed using a phased approach (see Robertson *et al* 2013) using stabilisation and symptom management for individuals there for short or uncertain periods of time. For detainees who were there for longer they discussed examples of using Narrative Therapy.

Emotional wellbeing group (Gatwick)

Brook House runs a weekly emotional wellbeing group for up to eight detainees. It is based on a one contact model, given the fast turnover and uncertainty around length of stay. In reality, many of the detainees went more than once and there were some who had been going for several months. The approach uses psychoeducation to think about the impact of living in detention on anxiety and activating the ‘fight or flight’ system. It uses visual aids, such as “the tap and glass model of stress” (Powell and Enright, 1990). Key to the approach was actively listening to the participants and validating their distress, trying to build up their self-compassion and pointing out examples of where they demonstrated resilience and coping skills. The groups draw on a range of approaches from cognitive behavioural therapy (CBT), occupational therapy and using a solution-focused approach.

Detainees discussed how helpful they found this space because they felt listened to and able to offload: “what’s inside, I can take it out”. Detainees also valued the peer support component of the group, where people were able to support one another through their difficulties. Peer support was cited across centres as key to managing wellbeing; for example, a group of older Jamaican men described how they met to play dominoes every afternoon. Several staff and detainees discussed the value of peer mentoring in prison. Although difficult to put in place in IRCs because the “peers” are also in the midst of the uncertainty, staff did suggest the possibility of employing individuals who have been released as experts by experience to provide a peer mentoring role.

Longer-length detention wellbeing reviews

Only Campsfield House offered reviews of physical and mental wellbeing routinely for those detainees who were experiencing longer detentions. At Campsfield House when a detainee had been with them for three months they were invited for an interview on their wellbeing at health care. The health care manager had developed an interview tool for this.

Partnership and collaborative working

There were reported delays in transferring detainees to hospital under the Mental Health Act across several of the IRCs (this is described later in the 'Challenges' section of the findings). Sussex partnership provides dedicated hospital beds for detainees at Gatwick IRC and was cited as key in reducing transfer times for those requiring admission under the Mental Health Act.

In all the centres there was very close working relationships with the chaplaincy and welfare teams (teams employed by the security provider to provide advice and in some cases advocacy on a range of issues). The chaplaincy team was recognised as playing a key role in providing culturally sensitive support. Detainees across sites consistently referred to the crucial support they received from the religious groups in the centre and in being part of that community. They were often described as more accessible than going to see someone in mental health. Some centres (for example, Gatwick) had taken this a stage further and have embedded the chaplaincy into the care team, having trained counselling roles and ensuring they participate in ACDTs.

Consultation groups with detainees

At both Gatwick and Campsfield House, stakeholders discussed holding consultation meetings with detainees to make sure the service meets the needs of the population. For example, at Gatwick, over-55 year olds asked for a coffee and bingo morning to be put in place. Centre for Mental Health were able to attend one such group at Campsfield House. Lewis and Meek (2016) report that The Verne runs service user forums that health care representatives attend. This appears to be similar to the group at Campsfield House. The Verne’s Health care department has previously attempted to run health care specific forums but these were poorly attended.

9. Challenges

Before detention

There was an expressed desire both by NHS England and the Home Office that vulnerable people should not be detained as stated in the Home Office Adult at Risk draft policy (UK Visas and Immigration, 2016). There is currently a missing component in the process of making the decision to detain someone. At the moment there is no screening in place to detect vulnerability before the decision is made to detain. It was reported to Centre for Mental Health that in most cases vulnerability is discovered after detention.

Any pre-screening process would need to be completed independently from the Home Office by a competent health practitioner who is qualified to assess a person's vulnerability and potential impact of being detained and this process is without the purview of NHS England. NHS England currently commissions an equivalent type of service in courts, youth offending services and police custody suites for over 70% of the English population. These liaison and diversion services screen and assess for a wide range of vulnerabilities and guide decision makers as to where to place suspects and offenders. Although not possible to screen all detainees before they enter detention, it should be explored how best to detect such vulnerabilities, which might impact decision making on immigration detention.

Employing screening tools would create huge challenges in many cases of detention; for example, where migrants have entered the UK concealed in heavy goods vehicles (commonly referred to as “lorry drops”). However, in cases where prison mental health teams or Liaison and Diversion services in courts and custody are involved, staff should be mindful of the needs of vulnerable individuals and raise concerns regarding the impact of detention. Those that come through police custody could be screened where an existing Liaison and Diversion service is in place. The operating model for such services could be adjusted to include screening all such detainees (currently many Liaison and Diversion services screen 100% of some

groups, for example women and those under 18 years). Likewise, screening could be undertaken for any detainee in court served by a Liaison and Diversion service. For those coming from prisons it would be possible for mental health professionals within the prison to conduct a screening or fuller assessment for those not known to them and to provide an existing assessment where they are known to the mental health teams (the latter does usually happen, if not always in a timely manner).

Short-term holding facilities such as Pennine House do hold people for long enough periods for screening to take place and might also benefit from the extension of the NHS England's Liaison and Diversion system. For those detained from other sources (e.g. lorry drops) providing a pre-screen is more challenging and is not currently part of NHS England's remit.

Communication

On arrival, there is no guarantee of information flow regarding an individual's vulnerability from the detention source (such as from the community or prison) to the IRC. Stakeholders working in IRCs said that there was greater chance of getting information from the Criminal Justice System and psychiatric hospitals, but not necessarily timely access as the information may arrive after the detainee had been screened, rather than with the detainee to form part of the screening. It was exceptional for someone to arrive with their notes available. By the time practitioners in the IRC had sought consent for the notes, contacted the previous provider and received the information, the individual had often moved on.

Screening

Screening took place throughout the day and night, and seemingly in less time-pressured circumstances than other custodial settings. However, screening for learning disability, autistic spectrum disorder and acquired brain injury were all perceived as “weak” and “very limited”. Some IRCs had screening tools for learning disability. None reported

having, for example, the tool developed by the Disabilities Trust for acquired brain injury (used in some prisons and by Liaison and Diversion services in police and court custody). Whilst the general reception screening process was standard across all centres, the training in, and availability of, validated screening tools was variable.

All detainees receive an initial screening on arrival, and are offered a GP appointment, but do not have an automatic second stage screening as is common practice in prisons (in prisons this usually occurs 48 -72 hours after arrival).

24 hour reception

The reception in IRCs is open 24 hours a day and therefore people will arrive and leave at any point in the day. Some staff commented that the vans travel at night to avoid daytime traffic. However, this means that individuals arrive late in the night, which staff observed meant they were very sleep deprived. One detainee, aged in their 60s, told us:

“I was at a friend’s house at 8:30 in the morning when the house got raided... I was taken to a police cell for 12 hours which was very cold. I didn’t cry all day as there was a bible and I was praying. It was when I asked [for] a blanket and they wouldn’t give me one and I asked why, and they said, “that’s prison for you”...that was when I started to cry. I was taken to [IRC] and got into my cell at about 4am. Because I had some PJs I wasn’t given anything as they said it was only for people who had nothing. I asked for a shower and was told I had to wait until morning. I was then moved to [another IRC] 3 days later”.

This was one example of many we heard. It needs to be asked whether moving an older adult in the middle of the night to detention is the most humane way of managing that situation. It also has to be questioned just how reliable a screening will be if performed under such circumstances, and especially as there is no automatic follow-up process.

Access to primary care

Access to the nurse triage element of primary care was reasonable across all IRCs, and although accessing a GP appointment was more variable, smaller centres could often provide same- or next-day access. The larger establishments tended to have ‘application’ type processes for seeking health care appointments, not too dissimilar to those in prisons, and these were felt by detainees to delay things. Smaller IRCs, like Campsfield House, could guarantee same day triage and often GP appointments, whereas the Heathrow IRCs might take up to two days for a nurse triage appointment and longer for a GP. When compared to access in the community, IRCs might appear to compare well, but detainees do not have access to alternatives (e.g. advice from a local pharmacist) and, as described earlier, their very detention can pose significant challenges to their mental and physical wellbeing.

Rule 35 Assessments

Some IRCs had longer waits and backlogs in assessments for Rule 35. Changes in the definition of what ‘torture’ consisted of were seen as having increased demand, and larger centres had longer delays, for instance Harmondsworth at Heathrow. Campsfield House also reported the increased demand but at the time of review were able to complete assessments within two days of referral.

ACDT reviews

The ACDT process is being used effectively across centres to support and manage individuals at risk of suicide or self-harm. All appeared to be involving appropriate services within the centre in the review to ensure that individuals were best supported. At some centres, for example Gatwick, staff mentioned involving the chaplaincy, recognising the role they play in providing support. However, staff discussed that the training for managing someone on ACDT was varied and often basic. For example, there was little training on how to ask questions relating to suicidal ideation. Questions were also raised regarding the appropriateness of having 4-5 staff sitting in

on the meeting with one detainee. From our observations and interviews, we questioned how safe the detainee might feel to talk openly about their vulnerability in front of several members of staff.

Hospital Transfers

The longest time cited for a transfer to hospital was four weeks (at Yarl's Wood), and it often took between two-three weeks. This was seen to be caused by the shortage of beds. This measure counts from the point at which someone is assessed to the point the detainee is accepted to a unit. In reality there may be 1-2 weeks prior to this when the mental health team at the IRC assessed the need for transfer and made the referral. Therefore the actual delay experienced by the detainee might, on occasion, be five weeks. For a small mental health team, looking after someone who is too unwell to be in detention takes up huge resources. At some IRCs, staff discussed having to use the care and separation unit or segregation unit for people whilst waiting for a transfer as the best environment for unwell detainees at the centre. However, staff commented on how this made them worse, increasing paranoia and isolation. The separation unit is not an acceptable place for someone to stay; however it was seen as the lesser of two evils. The overarching concern is that people who have been assessed as needing hospital treatment are not receiving it within appropriate timescales.

Removal

One of the 'ethical' challenges for mental health care staff concerned the removal of a detainee where it was felt by staff and managers in the IRC that if the detainee had advance knowledge of their removal this would increase risk of suicide and self-harm. We were told how this led to refraining from telling someone they were being removed until legally required to. However, the lack of transparency does contribute to a lack of trust towards staff and a "culture of fear". Clinicians found this one of a number of "ethically challenging" issues they faced working in IRCs. It also means that support before the removal is not always geared towards building up a detainee's coping skills.

Clinicians discussed how they often had no time to help someone prepare for being deported, sometimes receiving notification after a removal had happened. If they were given a time-frame, they might be able to provide some "stabilising" support (e.g. developing coping skills, linking up with possible support systems) towards that. For example, the communication between the mental health team and Home Office at Morton Hall means that the intervention can help equip detainees with skills they can use following removal. One detainee told a clinician that he would take the coping skills he had developed through the psychological sessions away with him.

Health care staff often had concerns over the likelihood of a detainee's deterioration in wellbeing after removal where it was uncertain or unlikely that continuity of care could be achieved in the country they were being removed to. Staff discussed the difficulties of trying to support someone when there was no assurance of the care they would receive on return or even if they would be okay. Detainees talked about fear of death and torture on returning and clinicians felt they could do little to reassure them.

Leaving an IRC and continuity of care

When the decision has been made to release someone, staff reported that they were usually released in the space of approximately two hours. In seeking to ensure that no one is unlawfully detained, the rapid release does mean that if the individual is a patient with a centre's health care, nothing is being done in relation to continuity of care. Mental health staff discussed individuals going off to court and then being released from court. This is most troubling when a detainee has need of secondary mental health care support.

"...so they are stable with us here, we see them regularly, they take their medication... then you're told they are being released...I have had that on a Friday afternoon and you try finding someone to refer them to on a Friday...I've just crossed my fingers and hoped they make it through the weekend..."
(Mental health team member)

Accounts similar to the above were given at all the IRCs visited. Short notice releases were always a problem, but somewhat less problematic if the detainee was being released to an area where the IRC mental health provider was also the provider for that locality. We were informed this is rarely ever the case.

Regarding the individuals being released, those who caused the greatest concern were those with enduring mental illness, and the concern was often related to a likelihood of relapse if a similar treatment regime was not accessible (e.g. current or equivalent medication) for any reason. As stated elsewhere, the health care and mental health care teams were small and had little in the way of capacity to explore the likelihood of treatment continuity overseas.

Access to rooms and equipment

Centre for Mental Health observed across the centres an inadequate number of private rooms with the necessary facilities for clinics and therapy to take place. In some cases health care rooms did not have translation facilities and the offices on the wings (that could be used for assessment or therapy) did not have access to SystmOne and the necessary health background information. There needs to be adequate private and safe spaces with the necessary translation equipment and readily available clinic notes, for reviews and therapy to take place.

Non-attendance of mental health appointments

Across the centres the 'did not attend' (DNA) rates for mental health appointments are quite high and up to 50%, but 30-40% being typically reported (higher than rates reported previously, see NHSE, 2015). There are several reasons for high DNA rates, such as the fast turnover and people moving on, other meetings taking priority for detainees (for example, legal visits), residential staff shortages limiting escort availability, limited capacity and facilities for 'outreach' (seeing detainees in the residential units) and patient willingness to engage. With regards to the latter, staff observed that when individuals are particularly distressed they may

not want to leave their room and come up to health care. There is also stigma around going to mental health support services, particularly amongst some cultures.

Although challenging and reliant on resources, an outreach approach with an emphasis on engagement may provide the flexibility some detainees need. With access to private and safe spaces on the wings, health care staff could go and engage individuals in a more informal manner. Addressing emotional and mental wellbeing may be less stigmatising for individuals, who may not see themselves as having a mental health problem but are experiencing increased stress and distress since being detained.

Experiences of being ignored or mistreated

Most of the detainees discussed their perception that they were not listened to, not taken seriously and treated as if they were lying by both health care and security staff (e.g. GPs, mental health nurses and officers) whilst in an IRC. Some discussed how individual staff tried to help them but the system made it impossible to achieve anything:

“Here you go round in circles...no one helps. It's not anyone's fault but it goes round in circles. I've been putting the blame on health care but they're not getting listened to by anyone else...”

Detainees discussed difficult interactions with officers where they had been “treated horribly...lots of manhandling” and experiences of coming back from the airport “covered in bruises”. Several detainees described how this contributed to a “culture of fear”, where they were “scared” of some officers and therefore less likely to express vulnerabilities or ask for help when experiencing psychological distress. This was described as exacerbating levels of mental distress already experienced, heightening the risk of detention as a re-traumatising experience. Additionally, detainees discussed the impact of not wanting to ask for help and that it was better to “keep your head down” and keep quiet, therefore increasing the risk of unmet needs not being detected.

Although officer conduct falls outside of NHS England's remit, it is important to recognise that wellbeing is the responsibility of the whole establishment. Any aspect of the regime or detention experience (e.g. difficult interactions with staff) which exacerbates mental health vulnerability, risks increasing the burden on mental health services.

New Psychoactive Substances (NPSs)

NPSs (e.g. synthetic forms of cannabis and tablets with similar effects to ecstasy and amphetamine) are a considerable problem across the prison estate, in the community, and in parts of the IRC estate. All IRC health care teams reported incidence where they had suspected use, giving examples of marked and rapid deterioration in both physical and mental health. Centre for Mental Health was given one account where a more vulnerable detainee was allegedly encouraged to try out a substance before other detainees took it. Similar accounts have been given in prison. NPS use has been a major challenge to the limited resources in IRCs, both in terms of security escort for those requiring external hospitalisation and in terms of stretching a limited health care resource.

Prison culture

Detainees arrive in IRCs from different settings. A significant group in all IRCs has come from prison and these are mixed with those who have previously been in the community. There is a perception amongst both staff and detainees that some detainees bring with them a prison "mentality" or "culture" when coming from prison. For detainees that have come from the community this 'mentality' or 'culture' could be experienced as threatening. There were accounts of bullying that were associated with this mentality or culture:

"...It's about being top dog..."

The use of drugs and in particular NPSs were associated by staff with this 'mentality' and 'culture', though this is a perception and it was not possible for the needs analysis to substantiate.

LGBT issues

Several of the men we spoke to reported that they were gay. All reported suffering psychological and physical abuse (two men reported being kidnapped and beaten by civilians in their community in their country of origin, and another reported being sex trafficked) as a result of this in their home country. All reported that UK Visas & Immigration Service was suspicious of their reported sexual orientation. Likewise all reported fear for their life if 'removed'. One commented that he did not feel safe revealing his sexuality in his IRC as he reported that many detainees held homophobic views, and he worried for his safety. Such a concern adds to the burden on a detainee's wellbeing.

One member of staff also reported that other LGBT people could feel threatened if their orientation was known, and especially amongst people from their own ethnic or cultural group.

Although this issue does not directly involve health care staff, it is crucial that aspects of detention that affect wellbeing are considered across the whole establishment. Detention circumstances like those described by LGBT detainees were perceived to adversely affect wellbeing and therefore impact upon health care provision.

Challenging behaviour and distress

Concerns were raised across centres about security officers' abilities to recognise and respond to signs of mental distress:

"...sometime a detainee 'kicks off' because they are distressed and just don't feel listened to..."

Those we interviewed believed that some challenging behaviours were the result of distress and were with different management possible to prevent.

One commonly discussed concern was how aggressive outbursts were responded to with sanction rather than addressing the cause of the behaviour. Security interviewees were worried

that behaviour was not recognised as having an underlying mental health cause, and that even if it was, staff did not have the skills to manage.

Staffing

All centres were visibly short-staffed and discussed challenges with sick leave, recruitment and retention. Staff discussed how it can take four to five months to get someone vetted and in post and therefore many take other jobs as the process is too long. Additionally, some staff discussed how the expectation of working there is very different from the reality and so they leave. It was described by several staff as an environment which “you can either hack or you can’t”. Across the centres, the mental health teams were very small and described as “isolated”. Staff discussed how there was a lot of sickness, often long-term, which we witnessed whilst on visits. Staff commented across centres that they “were not cared about”. This was perceived to be the case because of the lack of career development potential, training and clinical supervision.

Staffing shortages were also seen as creating tensions between security and health care, e.g. there were instances where health care requested putting someone on constant observation but it was contested by officers because they did not have the capacity to do it.

Staff commented that unless the staffing gets addressed it is not possible to run the interventions being suggested and put in place. For example, psychosocial groups can only run if there are the resources to run them. This includes having enough officers to escort detainees to the sessions.

Culture of ‘othering’ and disbelief

Some staff reflected how easy it was to become part of a culture of disbelief and “othering” the detainees:

“Unless you have deep rooted values about human beings it’s easy to be swept up by the culture of disbelief. I’m seen as naïve...”

Several staff discussed how they perceived this culture as a defense and coping mechanism to working in such a difficult environment with minimal support. Staff discussed how everyday they witness such distress and hear “these awful stories and there is nothing you can do to help”. They discussed how it resulted in people becoming desensitised. One staff member discussed the potential impact:

“I’m afraid that either I will lose my sense of care or I’ll lose my mind”.

The impact on staff wellbeing of working in what was described as a “toxic environment” was perceived to affect the quality of care that was provided in the centres. One staff member stressed how they had made this case several times to inspectors but the culture did not change.

Staff felt this required better supervision, training in emotional resilience and building in reflective practice to tackle the deep-rooted culture. The change would need to come from leadership and be embedded into contracts:

“There would be people who’d be keen, people who’d be resistant and everywhere in between...it needs to happen from the leadership and there needs to be role models of people with different attitudes towards detainees...”

Supervision

Very few of the mental health practitioners encountered in the review had access to regular supervision. This was particularly concerning given the complex nature of the setting, which included a presumption of disbelief in detainee accounts (perceived by mental health staff); the traumatic nature of many detainees' reported histories; the considerable time pressures; and ethical challenges to mental health practice.

Several mental health practitioners felt they needed time and space to reflect:

“...everything is so busy, you rush from one thing to another and there is a real danger of becoming cynical and absorbing the custody culture...”

“...I think some of the things we hear are really difficult and I don’t really get much opportunity to talk things through, we really should have supervision here...”

Though the review did not conduct interviews with security staff working in the IRC residential settings, it was the view of some mental health practitioners that they too ought to be offered some form of reflective support, perhaps a “dilute” form of supervision:

“...it’s a really challenging environment for everyone who is here...”

Not all health care and mental health care staff felt they had adequate access to debriefing when untoward incidents took place. The issue possibly lay in the definition of an untoward incident:

“...I don’t think it’s just about violence or deaths...sometimes a decision is made [reference to ‘removal’] that we don’t like and it has an impact on us...I think if we had more of a reflective culture we might treat that as something worthy of debrief...” [Senior mental health practitioner]

Access to training

Mental health staff had variable access to training, with staff at Campsfield House arguably having had the least, under the previous provider, but with expectation that this might change under Care UK. Across all IRCs, mental health staff did not feel they had sufficient knowledge of trauma and needed training in both its assessment and management. They also felt they needed accessible ongoing support and active clinical guidance for more complicated cases. Although mental health training is an expectation under all contracts, Centre for Mental Health heard across IRCs that officers did not feel adequately trained. Officers described receiving basic training as part of the induction at both Yarl’s Wood and Morton Hall. Some officers and Home Office staff had received further training. Centre for Mental Health felt the training offer needed closer monitoring across IRCs.

Dedicated primary mental health vs generic primary health support

Only one of the IRCs had a generic primary care service in which mental health nurses also provided a generic nursing role. This was Campsfield House, the smallest of the IRCs visited. Health care was very well received at Campsfield House and whilst most nurses enjoyed the mixed role, it was also observed that it was often challenging to offer anything beyond assessment, and on occasion even a timely assessment, due to the competing demands of the nursing role.

Ethics

Working in an IRC has been described as extremely ethically challenging by health care and mental health care staff. Clinicians are working with people detained against their will, in extremely uncertain circumstances and with uncertain futures. They are being told distressing stories about their lives and the fears they have of returning and discussed feeling powerless to help:

“You can do nothing to reassure them, well all you can reassure them of is that they won’t be here forever... I feel like I’m letting these people down as a clinician...”

To address this challenge requires robust and regular clinical supervision. There needs to be a space where staff can discuss how they feel have “failed” or felt compromised as a clinician.

Centre for Mental Health had the opportunity to observe clinical reviews where the ‘removal’ of a detainee was imminent and to see just how challenging it was for mental health practitioners to ensure if there was any possibility of continuity. This mainly concerned detainees with severe and enduring mental illness. However, on some occasions it concerned a detainee with what mental health practitioner felt was marked trauma. They were concerned that ‘removal’ itself and the circumstances around their ‘removal’ were potentially re-traumatising.

10. The Commissioning Specification Template

The specification is much improved on the previous more generic custody template, which had been adapted from a prison custody health service specification.

Centre for Mental Health supports the emphasis on stepped care in both generations of template.

The current template like the first does not place enough emphasis on steps 1-3 and wellbeing and makes no mention of trauma, barring a passing mention of PTSD. The template does mention the need to develop pathways for personality disorder, which Centre for Mental Health would not dispute the need for, but would question why this warrants a mention

over psychological trauma. None of the clinicians we spoke to felt that there was a high prevalence of personality disorder in their IRC.

Many of the cases that primary care practitioners will deal with day to day in community settings will have a psychological cause/influence or will be complicated by psychological symptoms. This was felt to be all the more the case in an IRC and the template could place greater emphasis on the need for liaison support and skills for primary care practitioners as part of the service offer.

Short term holding facilities will require a further amended specification.

11. Discussion and conclusion

IRCs are very challenging settings in which to provide mental health and wellbeing services. Unlike UK prisons, the population of an IRC's mental wellbeing is challenged by detention itself and the risk to wellbeing increases with the length of detention. Those detained in IRCs are held in uncertain conditions and it is usual for a detainee to not have any certainty over their future. The need to vent frustration and manage low spirits, and the anxieties produced by detention, are obvious. A significant number of detainees report histories of trauma and of living with trauma symptoms.

All of the IRCs have been building elements of a psychologically and trauma focused approach to providing mental health care, and some have made greater advances in achieving this. Examples of this include the wellbeing service at Yarl's Wood, the emotional wellbeing group at Gatwick and trauma therapy at Morton Hall. Both emotional wellbeing groups were highly valued by the detainees. Centre for Mental Health spoke to and offered a range of 'simple' interventions, to support people in coping with stress. The development of IAPT type services in some IRCs is commended, but given the typical duration of stay, they will be of limited use without adaptation. Across centres, health care services were almost universally well received and deemed to be accessible by detainees. Overall, the services are typically bi-disciplinary, with psychiatric nursing being the main discipline and psychiatry being the other.

Approaches in line with NICE guidelines relating to offering "alternative therapies" for trauma (e.g. relaxation therapy), were offered across several IRCs. Such approaches are reported by clinicians in IRCs to benefit detainees experiencing stress due to the uncertainty of their status, whether they had histories of trauma or not. Currently those who are assessed for trauma have this done as part of a Rule 35 assessment, and will by and large have presented themselves to health care for this assessment.

Despite this move toward a more psychological approach, in Centre for Mental Health's view,

all IRC mental health services need to make greater steps towards achieving genuine psychologically informed and stepped care services. The mental health services are not by and large multidisciplinary as envisaged by the IRC Commissioning Specification Template. Most of the IRC mental health services remain somewhat more medically and psychiatry orientated, similar to secondary care in custody settings. Whilst there is a clear need for these medical and psychiatric skills, the bulk of the need concerns maintaining and improving wellbeing often with a population that might fall below the threshold of community mental health secondary care. Detainees wanted more opportunities to be listened to and more support in managing what is a difficult situation.

Centre for Mental Health support NHS England's commissioning of a stepped care approach to mental health provision, but feel that there needs to be greater emphasis on the lower tiers. Detainees experience considerable stress due to the uncertainty under which they live, and the support required is very often about managing living with this stress. Opportunities to vent and manage feelings (e.g. through relaxation and talking groups) are of primary importance and need expanding across the estate.

There is still a definite need for more complex interventions, particularly for those who have experienced trauma. Across IRCs, the mental health services were currently not able to meet the needs related to individuals experiencing trauma. There was quite limited support available for trauma across the IRCs and the majority of mental health staff we spoke with did not feel confident in assessing or intervening in trauma. Arguably Morton Hall had the most developed thinking around the model of care that offered psychological intervention for those with unpredictable duration of stay and those suffering trauma. However, like other IRCs, it was not able to deliver to the scale of need currently.

Centre for Mental Health was not made aware of any routine screening for PTSD, which NICE guidelines suggest should be in place for

such an at risk population (see section 1.3.3 NICE, 2005). Treating PTSD through trauma focused psychological intervention, often taking 8 - 12 intervention sessions (see NICE, 2005) is challenging in an IRC because of the short durations of stay, and powers and circumstances under which 'medical hold' can be applied are unclear. NICE guidance suggests that practitioners might be more proactive in screening for PTSD. Currently screening and assessment is patient-initiated through requests for assessment under Rule 35.

The USA based Substance Abuse & Mental Health Services Administration (SAMHSA, 2015) give some basic principles for a trauma focused approach to care and these include: realising the widespread impact of trauma and understanding potential paths for recovery; recognising the signs and symptoms of trauma in clients, families, staff and others involved with the system; responding by fully integrating knowledge about trauma into policies, procedures and practices; and seeking to actively resist re-traumatisation. Applying all of these and particularly the latter are hard in an IRC; the latter so because detainees may need to recount accounts of trauma for appeals purposes at a pace that is difficult to manage, may perceive they are disbelieved and for some the very experience of detention may be re-traumatising.

The detainees Centre for Mental Health spoke to who reported symptoms of trauma would be classed as chronic sufferers, and this is likely to be the case for many detainees. We were given accounts of detainees who had reported torture just days prior to entry to the UK and detention. NICE recommends for those suffering chronic trauma that alternatives to psychological treatment be available, such as relaxation therapy. Although adopted across several IRCs, it was Centre for Mental Health's view that the likely need outstrips provision.

The current system does not adequately assess for need amongst individuals who have been in detention for a longer period. Despite large turnovers of population each month, a significant group stay in detention for over a month, which is the period that the best available UK evidence indicates an increased

risk of deterioration. Centre for Mental Health think it is a reasonable expectation that, for those being held longer than 30 days, health care services should enquire after someone's wellbeing and offer to review how they are coping, and to re-review at regular intervals.

It is important that services reflect the specific needs of females in detention. The marked differences in severity of need between Yarl's Wood and the other IRCs where HoNOS was completed may reflect to a degree differences in item interpretation on the HoNOS scale, but doubtless do reflect the high levels of distress amongst its female occupants. The scores are in line with the accounts given by both staff and female detainees at Yarl's Wood. Women experience the same traumatic experiences as men (e.g. such as torture) but can also experience trauma that is specific to women, such as female genital mutilation. They are more commonly the victims of forced arranged marriages and many report being victims of domestic violence. Some were also parents and had anxieties over separation from their children. For those who had children in their country of origin, sometimes their migration had been about providing income for their children at home and detention meant they could not do this. Women therefore are likely to require care and interventions that acknowledge the differences in their experience and context.

The principle of equivalence applies in IRCs, and Centre for Mental Health was encouraged that both at a practice and a policy level the predominate definition of equivalence is not that health services should be 'the same as' those in the community. Rather, equivalence is a desire that the same outcomes be achieved for detainees as one would desire for a community population. The means of achieving this may be different to reflect the needs of this specific population and its unique context. Lines (2006) made this very recommendation when discussing equivalence in the prison population. In considering equivalence it is interesting to look at the strategy proposed for the general English population by the Mental Health Taskforce (2016). The Taskforce place greater emphasis on prevention and access to psychological intervention and also wish to see access to mental health crisis care becoming

24/7 by 2020/21. IRCs currently have 24/7 general health care provision, which is more than many custodial settings have, and most have mental health practitioners in attendance seven days a week. Few currently report having mental health trained staff at night.

Centre for Mental Health also thought IRCs were a setting that 'begged' for a more reflective practice and far greater access to clinical supervision for mental health practitioners. Most practitioners reported having little or no access to supervision. This is all the more important as these are small and often quite isolated teams. National guidance

on supervision tends to be non-specific, for example the Care Quality Commission's guidance on clinical supervision (2013) does not detail the appropriate model for mental health or detention settings and its section on 'frequency' states only that it should be 'regular' (page 8). Centre for Mental Health would argue that the standard set by Royal College of Psychiatrists' Quality Network for Prison Mental Health Services is the most appropriate. This standard states that clinical supervision should be at least monthly (page 15; Royal College of Psychiatrists, 2016).

12. Recommendations

Underpinning these recommendations is an assumption that those with marked vulnerability should not be subject to detention. Where possible this should be identified before detention, and where this vulnerability is identified after detention, the detainee should be released to appropriate care in the community or transferred to hospital care without delay.

Mental health and wellbeing screening

1. Prison mental health teams and Liaison and Diversion services in courts should ensure that information on detained immigrants' wellbeing and vulnerability is passed on to health teams in IRCs and, where appropriate, they need to raise concerns during the detention decision making process. This should be reflected in the operating models and guidance for Liaison and Diversion services and prison mental health teams.
2. IRCs require a standardised approach to mental health screening.
3. Any detainee should be offered a review of their mental wellbeing once they have been detained for more than 30 days and at three-month intervals thereafter.

Mental health and wellbeing support

1. All IRC mental health services should have a wellbeing focus and deliver the 'stepped care' model. All commissioners need to rigorously ensure that services reflect the stepped care model and that there is an appropriate balance between psychological offers of care and psychiatric and medical care, with the greatest emphasis placed on the former and clear pathways for those requiring specialist care.
2. Access to alternatives to psychological intervention such as relaxation therapy should be increased.
3. IRCs holding women should demonstrate that they have an appropriate gender specific response that reflects the different needs and context of women in detention. Treatment pathways for those experiencing trauma should be specified.
4. There should be a review of NICE guideline compliance, particularly with regard to the assessment and treatment of trauma.
5. We recommend that the availability of time-limited psychological interventions should be increased across all establishments. Future Health Needs Assessments at IRCs

should be required to provide more specific guidance on the resource required for each element of the stepped care Model.

6. Peer support interventions should be developed, including the potential for peer mentoring.

Staffing levels

1. All IRCs should have access to expertise that can guide appropriate interventions for supporting detainees managing the experience of trauma.
2. All IRCs should have ready access to a mental health crisis response 24/7. This can either be through having appropriately trained staff at night as well as during the day, or via a responsive on-call service during the night.
3. All IRCs should have access to mental health practitioners who solely have mental health related duties. This means that one or more staff as appropriate has a dedicated mental health function that is not secondary to a general health function for daytime shifts, seven days a week.

Staff training and development

1. All staff in IRCs should be trained in their role within the stepped care Model, and mental health practitioners should receive

access to training and clinical updating.

2. All mental health care practitioners should be provided with robust clinical supervision and have access to both peer supervision and one to one supervision at least once per month.
3. Mental health awareness training should be mandatory for all new IRC staff as part of their induction and all staff should have mandatory annual update training.
4. A forum should be created across all IRCs to allow for the sharing of good and evidence based practice between practitioners from different institutions.

Continuity of care

1. IRC health care staff should be given maximum possible notice of release to ensure continuity of care for the most vulnerable detainees (i.e. those at risk of relapse in health if released without an active care plan in place).
2. Planning continuity of care and access to appropriate mental health treatment for detainees following their removal (e.g. discovering whether their medication is available in their country of origin) should be centrally managed within the NHS and not the sole responsibility of individual IRC health care teams.

References

- Bosworth, M. & Kellezi, B. (2015) *Quality of Life in Detention: results from MQLD questionnaire data collected at IRC Campsfield House, IRC Yarl's Wood, IRC Colnbrook, and IRC Dover, September 2013 and August 2014*. Oxford: Oxford University. Available at: <https://www.law.ox.ac.uk/sites/files/oxlaw/mqld.pdf>
- Bower, P. & Gilbody, S. (2005) Stepped care in psychological therapies: access, effectiveness and efficiency: Narrative literature review. *The British Journal of Psychiatry*, **186** (1) 11-17.
- Cairns, C., Morris, J. & Tamlyn, R. (2015) *Pennine House – Short-Term Holding Facility, Manchester Airport: Health Needs Assessment*. Red stacks. Claire Cairns Associates Ltd
- Care Quality Commission (2013) *Supporting information and guidance: Supporting effective clinical supervision*. Available at: https://www.cqc.org.uk/sites/default/files/documents/20130625_800734_v1_00_supporting_information-effective_clinical_supervision_for_publication.pdf
- Durcan, G. (2016) *Mental Health and Criminal Justice: views from consultation across England and Wales*. London: Centre for Mental Health.
- HMIP (2016) *Report on an unannounced inspection of the short-term holding facility at Pennine House, Manchester Airport by HM Chief Inspector of Prisons 12 January 2016*. London: Her Majesty's Inspectorate of Prisons
- Lewis G & Meek R (2016) *Health Needs Assessment - The Verne Immigration Removal Centre*. May 2016. Provided with kind permission of the Authors and Sue Stadden, Head of Health and Justice Commissioning NHS England (South Central). Available from Professor Rosie Meek, Head of School of Law, Royal Holloway University of London, r.meek@rhul.ac.uk
- Lines, R. (2006) From equivalence of standards to equivalence of objectives: The entitlement of prisoners to health care standards higher than those outside prisons. *International Journal of Prisoner Health*, **2** (4) 269–280.
- McManus, S., Meltzer, H., Brugha, T., Bebbington, P. & Jenkins, R. (2009) *Adult psychiatric morbidity in England, 2007. Results of a household survey*. Leeds: The NHS Information Centre for Health and Social Care
- Mental Health Task Force (2016) *The five year forward view for mental health: A report from the independent Mental Health Taskforce to the NHS in England*. Available at: www.england.nhs.uk/mentalhealth/taskforce.
- NHSE (2015) *Health and Wellbeing Health Needs Assessment Programme: Immigration Removal Centres and Residential Short Term Holding Facilities National Summary Report May 2015*. London. NHS England.
- NICE (2005) *Post-traumatic stress disorder: management Clinical guideline*. Available at: <http://www.nice.org.uk/guidance/cg26>
- NICE (2011) *Common Mental Health Problems: identification and pathways to care*. Available at: <https://www.nice.org.uk/guidance/cg123/chapter/1-guidance>
- Powell T. J. and Enright S. (1990). *Anxiety and Stress Management*. London. Tavistock
- Robertson, M. E. A., Blumberg, J. M., Gratton, J. L., Walsh, E. G., & Kayal, H. (2013). A group-based approach to stabilisation and symptom management in a phased treatment model for refugees and asylum seekers. *European Journal of Psychotraumatology*, **4**, doi: 10.3402/ejpt.v4i0.21407. eCollection 2013. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24371509>
- Robjant, K., Robbins, I., Senior, V. (2009) Psychological distress amongst immigration detainees: a cross-sectional questionnaire study. *British Journal of Clinical Psychology*. **48**:275-286
- Royal College of Psychiatrists (2016) *Standards for Prison Mental Health Services – Second Edition – Quality Network for Prison Mental Health Services*. London. Royal College of Psychiatrists.

Shaw, S. (2016) *Review into the Welfare in Detention of Vulnerable Persons: A report to the Home Office by Stephen Shaw*. London. HMSO

Silverman, S. & Hajela, R. (2016) *Briefing: Immigration Detention in the UK (01/09/16)*. The Migration Observatory – University of Oxford. <http://www.migrationobservatory.ox.ac.uk>

Singleton, N., Meltzer, H. & Gatward, R. (1998) *Psychiatric Morbidity among Prisoners in England and Wales*. London: Office for National Statistics.

UK Visas and Immigration (May 2016) *Adults at risk in immigration detention: draft policy*. Available at: <https://www.gov.uk/government/publications/adults-at-risk-in-immigration-detention>

Wing, J. K., Beevor, A. S., Curtis, R. H., Park, S. B., Hadden, S., & Burns, A. (1998) Health of the Nation Outcome Scales (HoNOS). Research and development. *The British Journal of Psychiatry*, **172** (1), 11-18.

Appendices: topic guides and survey tool

	Please state number
Throughput and churn	
On 30/3/16 how many detainees have been present at this IRC for:	
1 year +	
6-11 months	
2-5 Months	
1 month	
2 weeks or under	
Detention process	
Out of the total number of detainees present at the IRC on 30/3/16, please state the total that had been detained from each of the following sources:	
Prison transfers	
From the community (e.g. Home or places the detainee was required to report to whilst in the community)	
Transferred from another IRC	
Airport	
Lorry drops	
Other (please specify)	
From those transferred from prison, how many had served a sentence of 12 months or less?	
From those transferred from prison, how many had served a sentence of 13 - 24 months?	
From those transferred from prison, how many had served a sentence of 25 months or more?	
Mental health intervention	
In the 7 days prior to 30/3/16 how many individuals received mental health or related assessments?	
In the 7 days prior to 30/3/16 how many individuals have been seen for an intervention for their mental health or a related vulnerability (e.g. learning disability, autistic spectrum, personality disorder) (excluding assessment)?	
Please add detail about these interventions below:	
In the 7 days prior to 30/3/16 how many medication reviews?	
In the 7 days prior to 30/3/16 how many care reviews?	
In the 7 days prior to 30/3/16 how many individuals attended group counselling/psychological intervention sessions?	
In the 7 days prior to 30/3/16 how many individuals attended one to one sessions for counselling/psychological intervention?	
In the 7 days prior to 30/3/16 how many attended another type of intervention (1) (please specify)?	

	Please state number
In the 7 days prior to 30/3/16 how many attended another type of intervention (2) (please specify)?	
In the 7 days prior to 30/3/16 how many attended another type of intervention (3) (please specify)?	
In the 7 days prior to 30/3/16 how many individuals have received onward referral for a mental health or related vulnerability in the past 7 days?	
In the 7 days prior to 30/3/16 how many mental health related appointments have not been attended in the past month? (Include interventions, reviews and booked assessments)?	
Transfers	
In the 12 months prior to 30/3/16 how many detainees have been transferred to hospital under a section of the Mental Health Act?	
How many detainees were awaiting transfer on 30/3/16?	
For those awaiting transfer on 30/3/16 can you indicate the number of days waited since referral for sectioning/transfer?	
For those transferred in the past 12 months prior to 30/3/16 can you indicate the number of days that each transfer took, counting from referral for sectioning/transfer to the day of transfer? Please place the number of days for each in an individual cell in this row.	
Medication	
In the last 7 days prior to 30/3/16 how many detainees have been treated with medication for depression?	
In the last 7 days prior to 30/3/16 how many detainees have been treated for problems with anxiety of stress with medication?	
In the last 7 days prior to 30/3/16 how many detainees have been on anti-psychotic medication?	
In the last 7 days prior to 30/3/16 how many detainees have been treated for problems with sleep with medication?	
Rule 35 and ACDT	
In the last 7 days prior to 30/3/16 how many detainees have been assessed for Rule 35?	
In the last 7 days prior to 30/3/16 how many detainees (regardless of when assessed) were deemed to meet the conditions for rule 35 part 1?	
In the last 7 days prior to 30/3/16 how many detainees (regardless of when assessed) were deemed to meet the conditions for rule 35 part 2?	
In the last 7 days prior to 30/3/16 how many detainees (regardless of when assessed) were deemed to meet the conditions for rule 35 part 3?	
In the last 7 days prior to 30/3/16 how many detainees have been waiting for an assessment for rule 35?	
On 30/3/16 how many detainees were on an active ACDT?	

Health of the Nation Outcome Scale (HoNOS) items

Age	
Gender	
Length of stay on 30/3/16	
Transferred from prison?	
Detained from community?	
Other? (please specify)	
Assessed under Rule 35?	

	Score
1. Overactive, aggressive, disruptive or agitated behaviour	
2. Non-accidental self-injury	
3. Problem drinking or drug taking	
4. Cognitive problems	
5. Physical illness or disability problems	
6. Problems with hallucinations or delusions	
7. Problems with depressed mood	
8. Other mental and behavioural problems	
9. Problems with relationships	
10. Problems with activities of daily living	
11. Problems with living conditions	
12. Problems with occupation and activities	

KEY:

- 0 - No Problem
- 1 - Minor Problem Requiring No Formal Action
- 2 - Mild Problem
- 3 - Moderate Problem
- 4 - Severe / Very Severe Problem
- 9 - Not Known

Interview topic guide with detainees

Reassure confidentiality at the beginning of the interview and that taking part will not affect their rights. State that this is a review that is trying to understand how mental health needs are met in IRCs and how to improve the mental health services available. State that they don't have to take part and if there are any questions they don't want to answer then they don't have to.

1. Can you start by telling me how old you are?
2. What's your country of origin?
3. How long have you been staying here?
4. How did you come to be in [IRC name]?
5. Have you stayed at any other IRCs?
6. Have you been transferred from prison? If so, do you mind telling me about the nature of your offence and how long you were in prison?
7. Do you know what is going to happen to you? What do you expect will happen?
8. How do you feel about that?
9. Do the staff tell you about what might happen next?
10. What is it like living here? Meaningful activity, "culture of fear"
11. If you have been in prison, how does it compare?
12. Are you in contact with family / people you know?
13. Is there anyone you feel that you can talk to or ask for help? If so, who are these people? Staff / detainees?
14. What is your experience of the staff? Do you feel listened to?
15. Whilst you have been here have you received any provision from the health service? What was it?
16. Have you received any provision from the mental health service here? What was it for?
17. What sort of provision did you get? How many times did you see some one?
18. What symptoms were you experiencing?
19. How long have you been experiencing those?
20. Have you had those symptoms before in your life?
21. What have you found to be helpful / not helpful when you have been experiencing these symptoms?
22. Have you experienced anything in your life that has caused you to feel distressed/ traumatised?
23. Have you asked for rule 35? If so, how is that being dealt with?
24. Have you been a victim of torture? How is that addressed here?

Interview topic guide for GP

Reassure confidentiality at the beginning of the interview and that taking part will not affect their rights or job. State that this is a review that is trying to understand how mental health needs are met in IRCs and how to improve the mental health services available. State that they don't have to take part and if there are any questions they don't want to answer then they don't have to.

1. How long have you been a GP?
2. Have you done training in any specialist areas?
3. What type of services have you worked in previously?
4. Who are you contracted with here?
5. Are you full-time here?
6. Was there specific training for this role? What was your experience of that training?
7. Could you give me an example of what a working day is like here? What is the work load like?
8. From your experience, what would you say is the level and type of mental health need amongst detainees?
9. Do you think those needs are being met? Why/ why not?
10. What proportion of the patients you see access you relating to their mental health?
11. Whats your experience of interplay between mental and physical health? Specifically, have you seen many people with psychosomatic symptoms?
12. What influence do you have on an individual's case? Examples where you feel someone is severely unwell and should not be in an IRC?
13. Could you explain the referral process here?
14. Once you have seen someone how easy is it for them to referred on and seen?
15. How do the procedures and practices compare to your experience in the community?
16. Whats your view on the mental health provision here?
17. How are notes kept and information shared between services within the IRC?
18. Rule 35 – pressures on institution.

Interview topic guides for mental health staff

Reassure confidentiality at the beginning of the interview and that taking part will not affect their rights or job. State that this is a review that is trying to understand how mental health needs are met in IRCs and how to improve the mental health services available. State that they don't have to take part and if there are any questions they don't want to answer then they don't have to.

1. Can you firstly describe your role?
2. Who are you contracted by? Who provides the health care here?
3. If we could start by discussing the screening process. What does the screening currently include? What are you looking for? *(Consider severe mental illness, vulnerability re self harm and suicide, substance misuse (inc NPS), common mental problems, exposure to trauma, risk factors (eg isolation), ASD, speech and communication, head injury).*
4. What challenges do you face when doing screenings?
5. How many people are screened by mental health on average daily?
6. How often are screenings repeated? For instance where someone might be here for a longer period (eg 6-12 months).
7. What's your impression of the level and type of mental health needs amongst the detainees here?
8. How well do you think need is being met?
9. What's your impression of the experience of detention on detainees mental health? Evidence that mental health might be deteriorating.
10. From your experience what would you say are the root causes of detainee/patients' mental health problems/vulnerability? Impact of detention / pre-existing mental health / exposure to trauma
11. What service do you provide? What does that look like?
12. What influence do you have on an individuals case? Say if you felt someone was too severely ill to be here – what influence would you have?
13. What challenges do health care face?
14. If not mentioned, how would you describe staffing and resources? What sort of resource do you need more of type? Specialism?

Interview topic guide for security staff

Reassure confidentiality at the beginning of the interview and that taking part will not affect their rights or job. State that this is a review that is trying to understand how mental health needs are met in IRCs and how to improve the mental health services available. State that they don't have to take part and if there are any questions they don't want to answer then they don't have to.

1. What is your impression of the mental health needs of detainees here?
2. What is your impression of the health service?
3. Unlike prison, IRCs have 24/7 provision. How does that work? What are the challenges?
4. What impact does the level of throughput have on the institution?
5. If/when you have a worry/concern about someone's vulnerability/mental health, what is the process in place?
6. Have you felt like those worries are well addressed?
7. What mental health training do staff receive? Are there refreshers?
8. What training do staff receive for ACDT?
9. Detainees are often experiencing great deal of uncertainty, what procedures are in place to help detainees to cope with uncertainty?

Immigration Removal Centres in England

Published January 2017

Photograph: istockphoto.com/PeopleImages

£10 where sold

Centre for Mental Health is an independent charity and relies on donations to carry out further life-changing research. Support our work here:
www.centreformentalhealth.org.uk/Pages/Appeal

© Centre for Mental Health, 2017

Recipients (journals excepted) are free to copy or use the material from this paper, provided that the source is appropriately acknowledged.

Register for our emails at
www.centreformentalhealth.org.uk



Centre for
Mental Health



Centre for Mental Health
Office 2D21, South Bank Technopark,
90 London Road, London SE1 6LN
Tel 020 7827 8300
Fax 020 7827 8369
www.centreformentalhealth.org.uk

Charity registration no. 1091156. A company
limited by guarantee registered in England and
Wales no. 4373019.