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INSTITUTE FOR CRIMINAL POLICY RESEARCH

AN ASSESSMENT OF THE HEALTH NEEDS OF DETAINEES IN WEST SUSSEX IMMIGRATION REMOVAL CENTRES – FINAL REPORT

ICPR
Institute for Criminal Policy Research

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Introduction

The commission

NHS Sussex and West Sussex County Council commissioned the Institute of Criminal Policy Research (ICPR) to undertake an assessment of the health needs of people detained in the two local Immigration Removal Centres – Brook House and Tinsley House - and the Cedars pre-departure accommodation.

The UK Border Agency maintains ten immigration removal centres around the UK. The centres are used for temporary detention, in situations where people have no legal right to be in the UK but have refused to leave voluntarily. Those detained can leave at any time to return to their home country. If detainees refuse to comply with the law and leave the UK, UKBA will enforce their return.

Some detainees are foreign national offenders who have completed prison terms for serious crimes, but who then refuse to comply with the law by leaving the UK.

There were six specific objectives to the health needs assessment:

- To examine the current health and social care needs of people detained
- To identify existing services and provision
- To identify gaps in services or barriers to services,
- To identify any training needs of centre staff
- To identify how the health and social care needs of children are being met
- To identify progress centres are making to address specific health and social care issues raised during HMIP centre inspections

The fieldwork for this study was carried out between February and May 2012.

Organisation of the report

This report is organised in a straightforward manner. Chapter One outlines the purpose and nature of the three facilities and provides a demographic profile of the detainee population. Chapter Two describes the methods used in the course of the study. Chapter Three presents a brief review of the literature relating to detainees' health. Chapter Four focuses on the physical health of detainees and Chapter Five on their mental health. Chapter Six presents our conclusions and recommendations.

Chapter 1: The Three Facilities

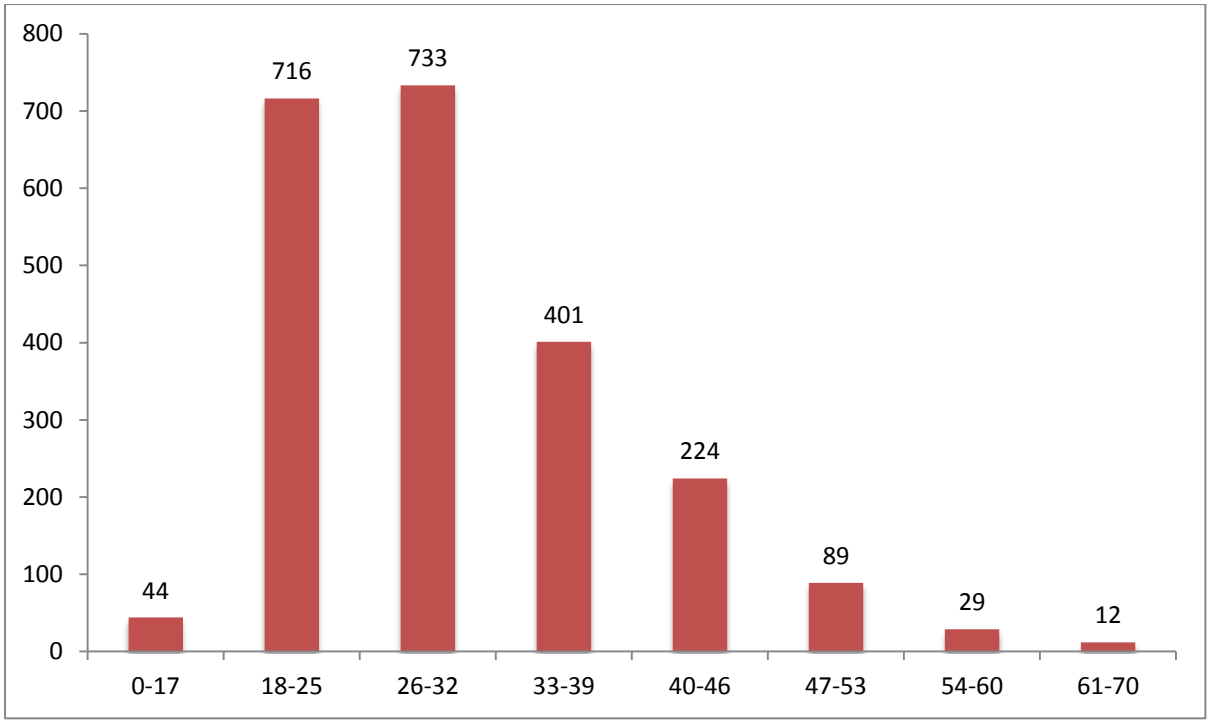
Tinsley House

Tinsley House is a purpose-built immigration removal centre which was opened in 1996. It is managed by G4S on behalf of the UK Border Agency.

It has bed spaces for 119 men and eight families. Accommodation for male detainees is in rooms accommodating between two to five people. The family unit is self-contained with eight family suites each with an en-suite shower room.

2248 detainees were received at Tinsley in 2011, just 54 of whom were female. Figure 1 shows the age spread of these detainees

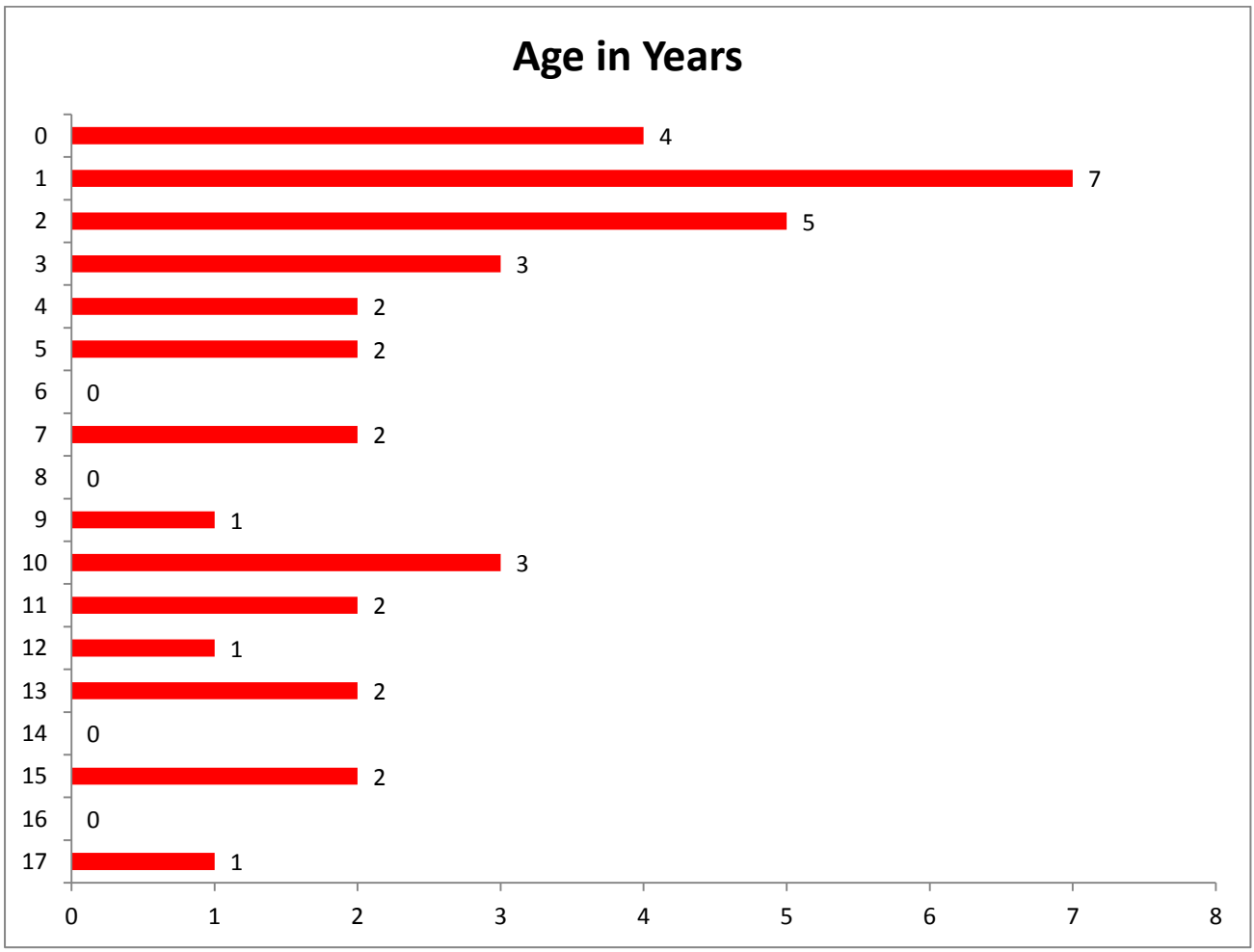
Figure 1 Age of Tinsley detainees



Most , detainees (83%) were aged between 18 and 39 years with just one in 50 (2%) children under the age of 18 years and one in fifty (1.8%) aged 54 years or older.

Additional information was requested about the age of the young people received at Tinsley in 2011. On this occasion, G4S provided information about 37 individuals as shown in Figure 1a.

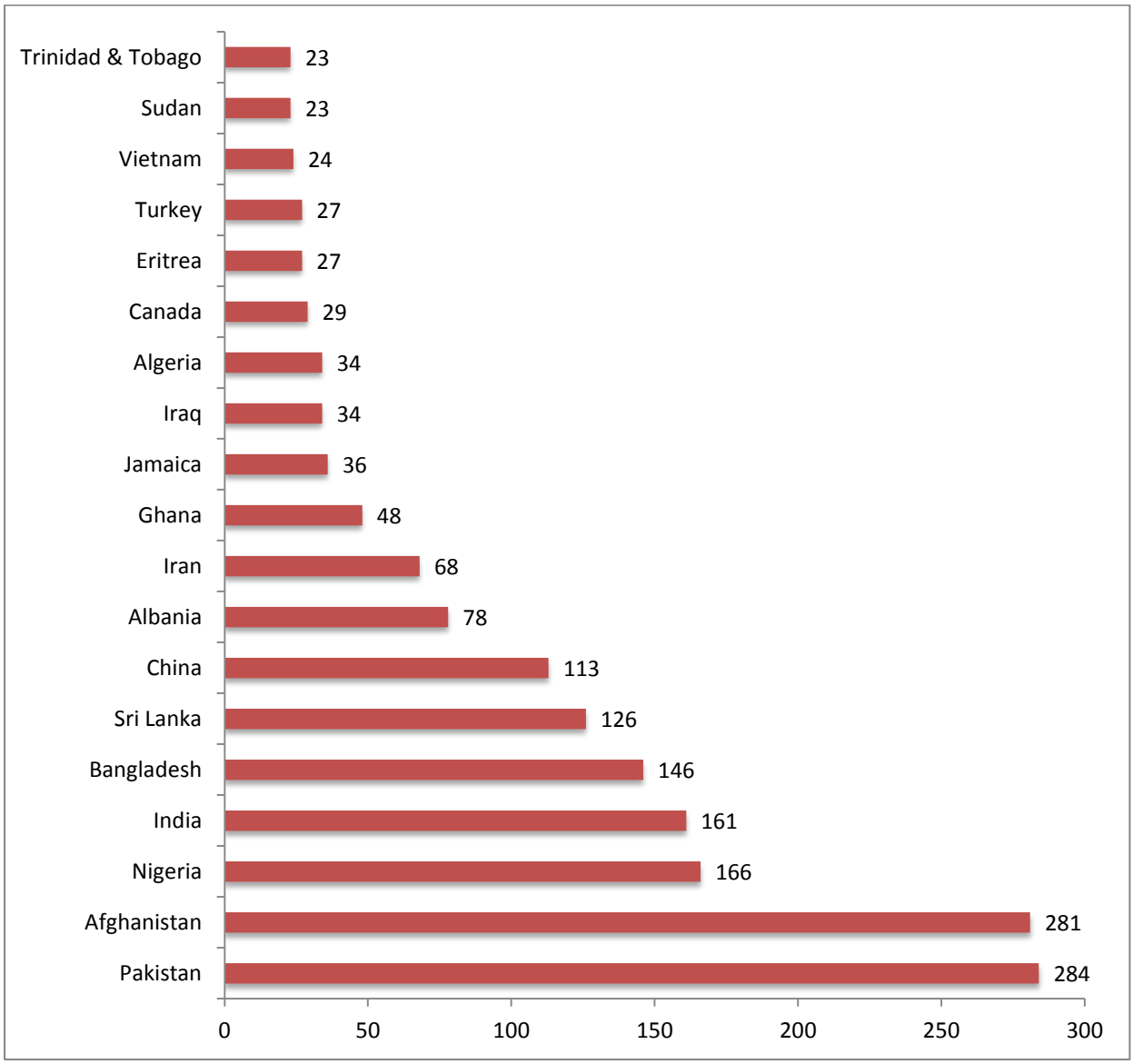
Figure 1a Age of Tinsley Young People detainees (n= 37)



It can be seen that more than half (21/37) of these younger people were children under the age of five years old.

Detainees originated from 106 different countries. Figure 2 shows the most common countries of origin for these detainees (only those countries from where at least 1% detainees originate are included):

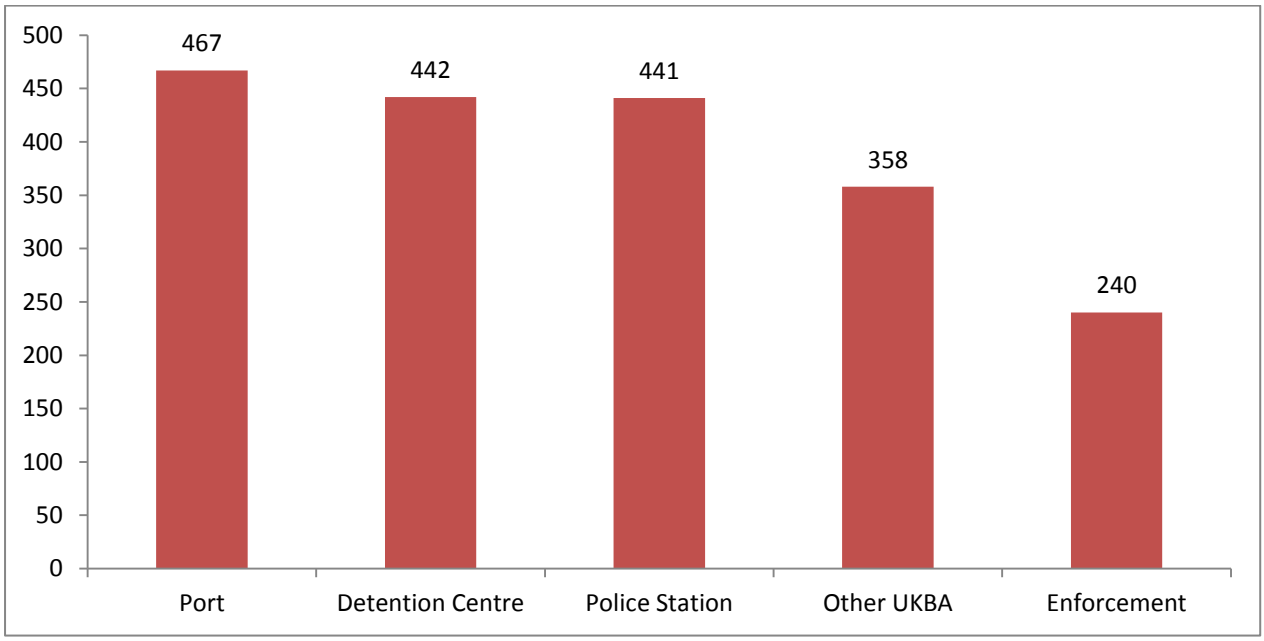
Figure 2 Country of Origin of Tinsley detainees



One in eight detainees originally came from Pakistan (12.6%) and Afghanistan (12.6%) respectively. One in fourteen detainees came from Nigeria (7.4%) and India (7.2%) and one in fifteen from Bangladesh (6.5%).

G4S were able to supply data on where 90% of these 2248 detainees were received from, as figure 3 shows.

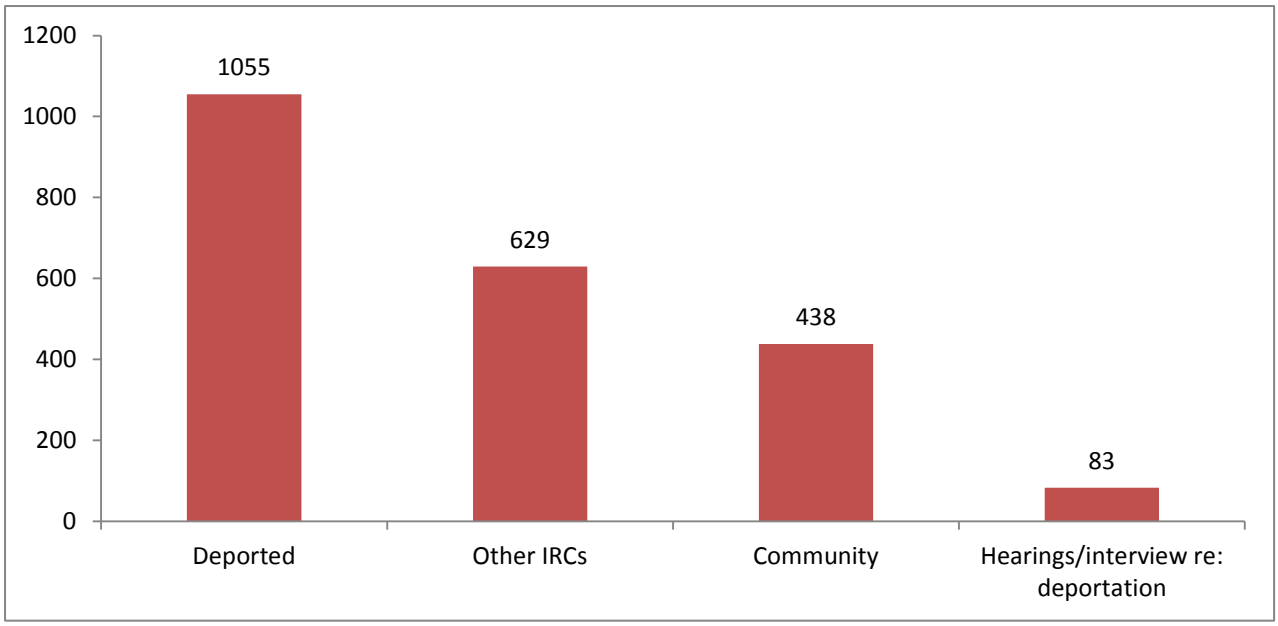
Figure 3 Source of reception to Tinsley (n= 2031)



The category "Other UKBA sites" includes a number of holding facilities at airports etc. In addition, 25 individuals were received from prison and 10 from failed removal directions.

G4S also provided information on the destination of the 2230 who left Tinsley in 2011, shown in figure 4:

Figure 4 Destination from Tinsley (n = 2230)

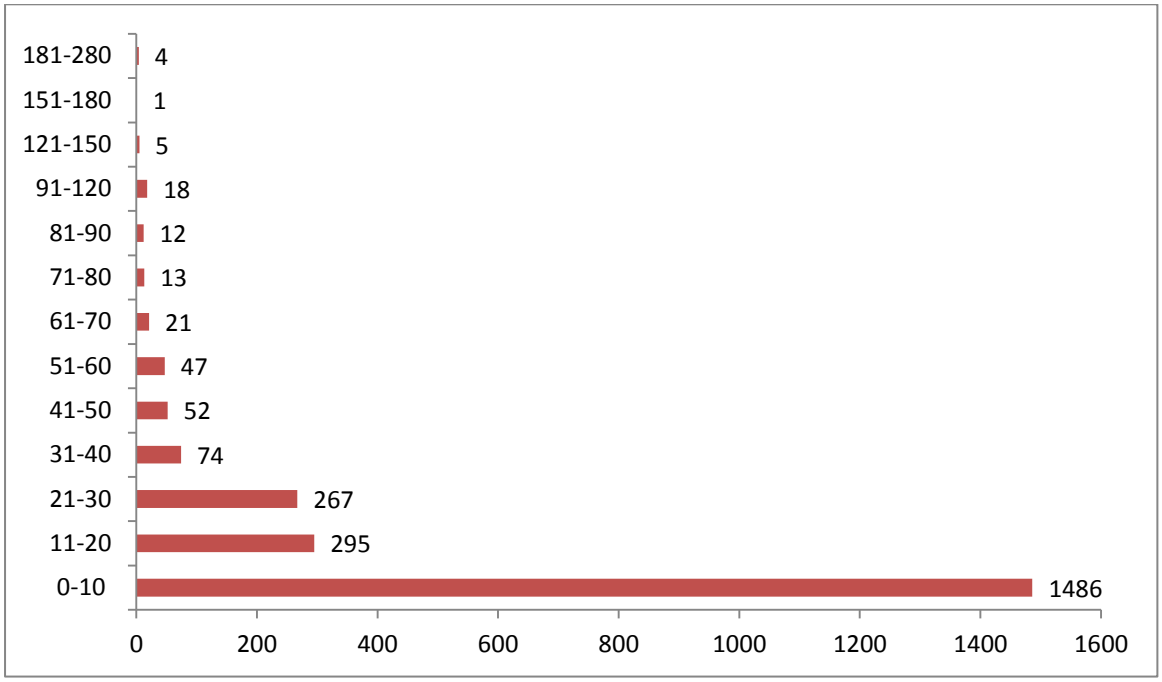


In addition, nine individuals were sent to court and two each to a police station, appeal hearing and hospital.

It can be seen that just under half detainees (47%) were removed. Therefore the other 53% would still potentially access medical care in this country.

G4S kindly provided information about the length of stay of the 2295 individuals who left Tinsley in 2011 as shown in Figure 5:

Figure 5 Tinsley Length of Stay in Days



Almost two thirds (65%) of people who left Tinsley House in 2011 stayed less than ten days with a further quarter (25%) being resident for less than one month. One hundred and seventy three detainees stayed for between two and three months and 46 for between two and three months. Just 28 detainees stayed longer than four months.

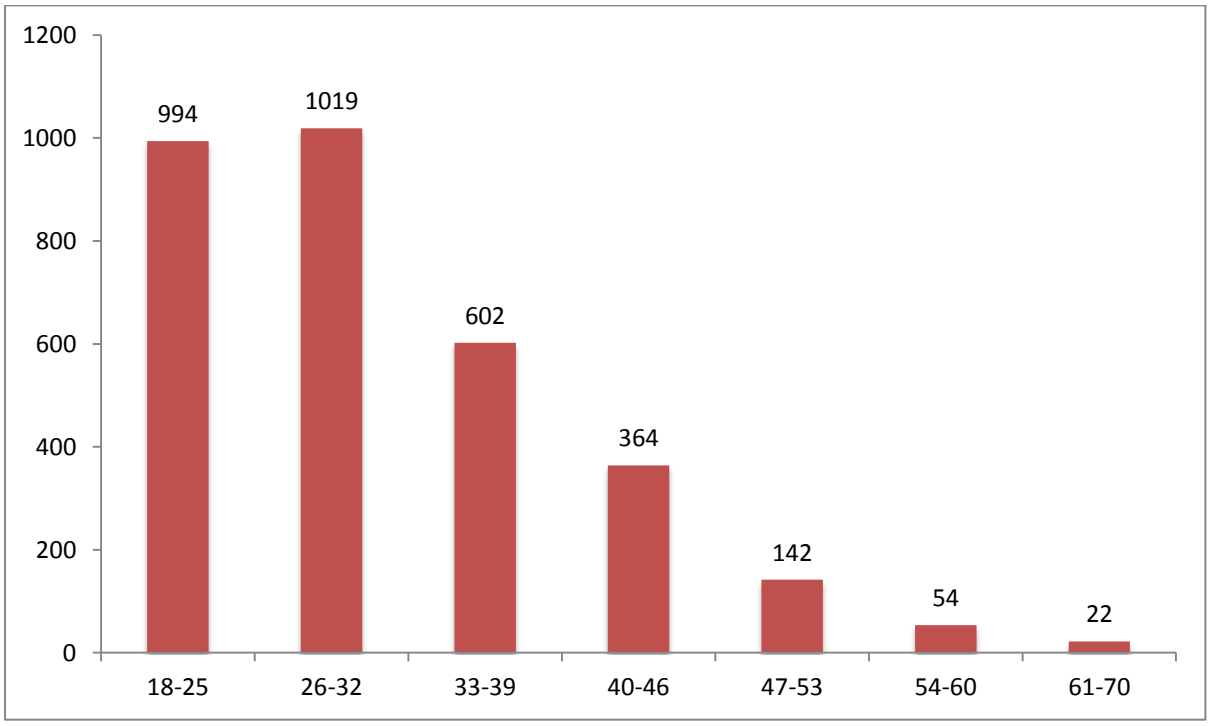
Brook House

Brook House is a purpose-built immigration removal centre which was opened in March 2009. It is managed by G4S on behalf of the UK Border Agency.

It is designed on a prison basis and holds a total of 426 male detainees in cells on four wings. There is part of one wing designed to hold people who are at risk of self-harm or who are temporarily removed from main accommodation for disciplinary reasons .

3197 detainees were received at Brook in 2011, figure 6 shows the age spread of these detainees

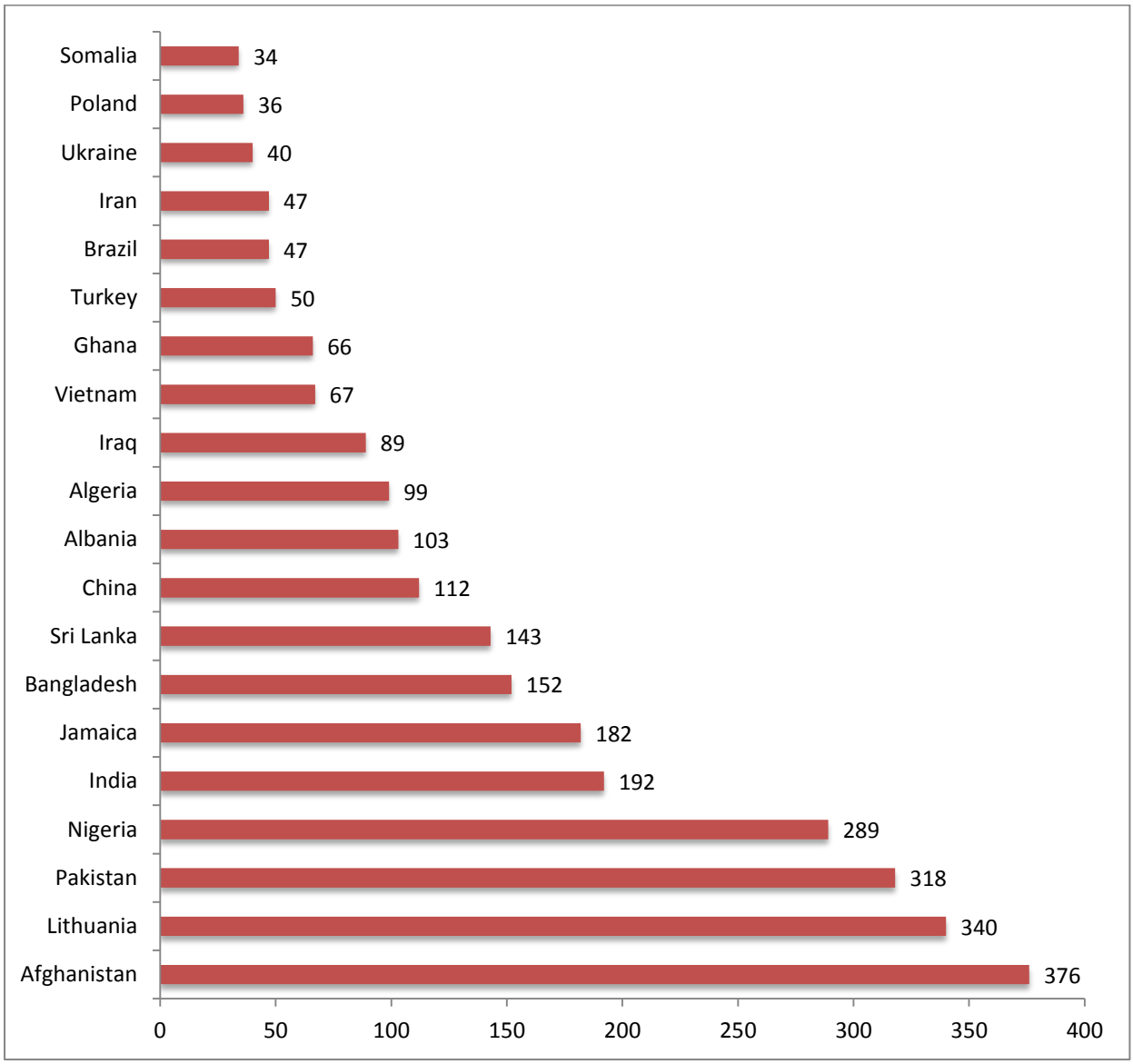
Figure 6 Age of Brook detainees



Just under two-thirds of detainees (63%) were aged between 18 and 32 years with just one in 42 (2.4%) aged 54 years or older.

Detainees originated from 143 different countries. Figure 7 shows the most common countries of origin for these detainees (only those countries from where at least 1% detainees originate are included):

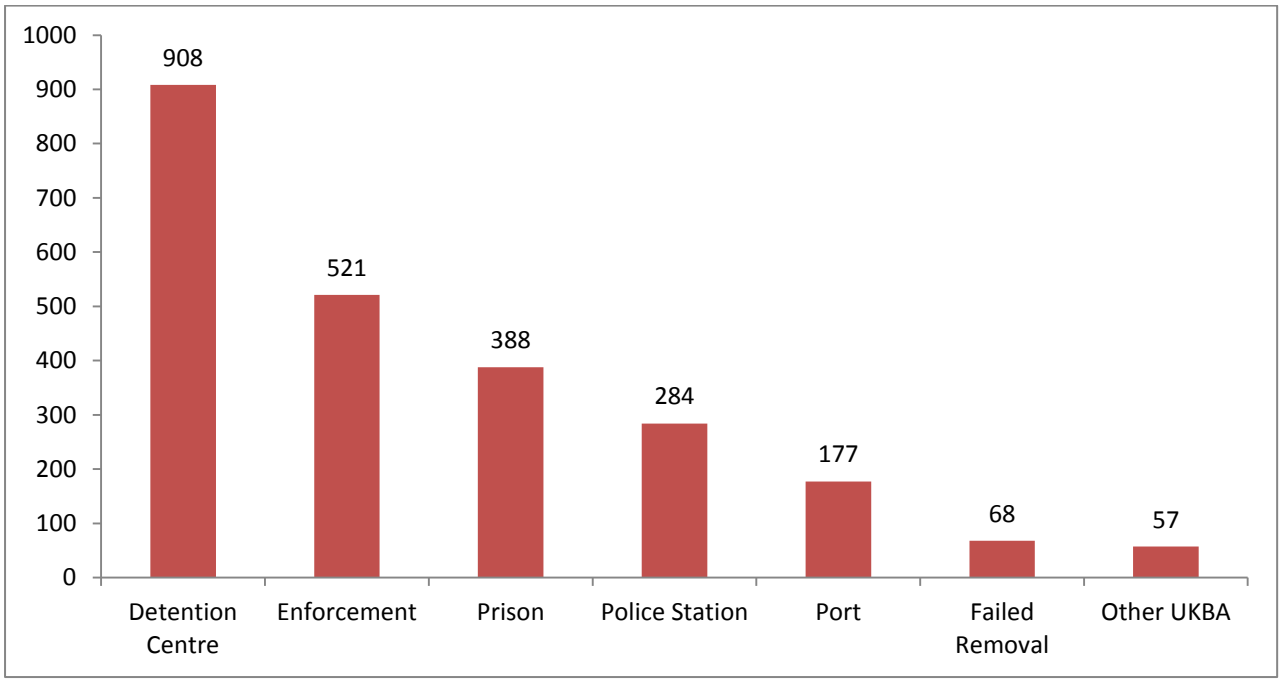
Figure 7 Country of Origin of Brook detainees



One in nine detainees originally came from Afghanistan (11.8%) and Lithuania (10.8%) respectively and one in ten from Pakistan (9.9%). One in eleven detainees came from Nigeria (9.2%). There were substantially larger populations of Lithuanians, Jamaicans and Algerians at Brook House compared to Tinsley.

G4S were able to supply data on where three quarters (75.7%) of these 3197 detainees were received from, as figure 8 shows.

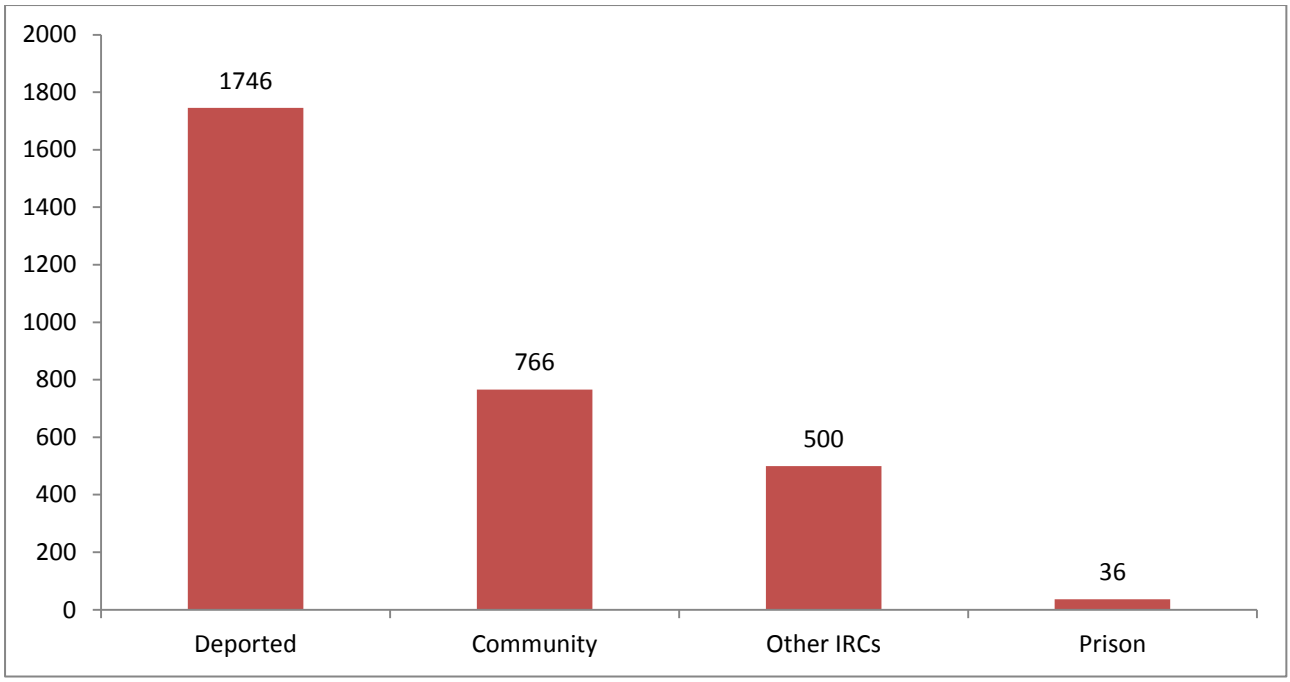
Figure 8 Source of reception to Brook (n= 2420)



A much higher proportion of detainees at Brook House came from prison compared to Tinsley (16% v 1.2%).

G4S also provided information on the destination of the 3073 who left Brook in 2011, shown in figure 9:

Figure 9 Destination from Brook (n = 3073)



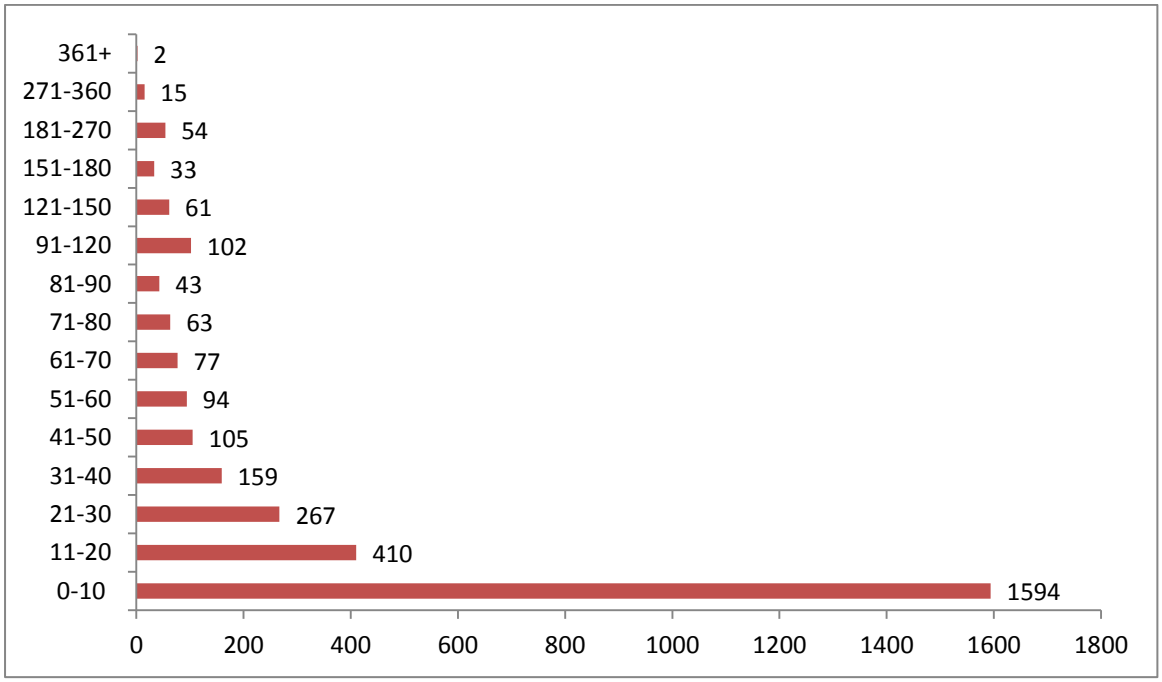
In addition, 17 individuals were sent to interviews and four each to a police station or court.

It can be seen that over half detainees (57%) were removed. Therefore the other 43% may still require medical care in this country.

Detainees are moved to different IRCs for a range of reasons including: to be closer to family; to be closer to airport from which they are to be removed; in order to better meet their needs; or because they are hard to manage.

G4S kindly provided information about the length of stay of the 3079 individuals who left Brook in 2011 as shown in Figure 10:

Figure 10 Brook Length of Stay in Days



It can be seen that the average length of stay at Brook House is longer than at Tinsley. Only just over half of detainees (52%) stay 10 days or less (compared to 65% at Tinsley) and a substantial minority of 267 detainees (8.6%) stay for 3 months or longer, compared to just 28 individuals or 1.2% at Tinsley.

Brook and Tinsley House are subject to inspection by Her Majesty's Inspectorate of Prisons. The compliance of Health services with Detention Centre Operating Standards is also audited by UKBA.

Cedars

Cedars is a brand new pre-departure accommodation for children and families which opened in August 2011. Only families who have been referred by an independent Family Returns Panel will be admitted. They may stay for up to 72 hours (extended to one week with express ministerial authority) before being removed.

Cedars is run by G4S with Barnardo's providing welfare and social care services to the families and children.

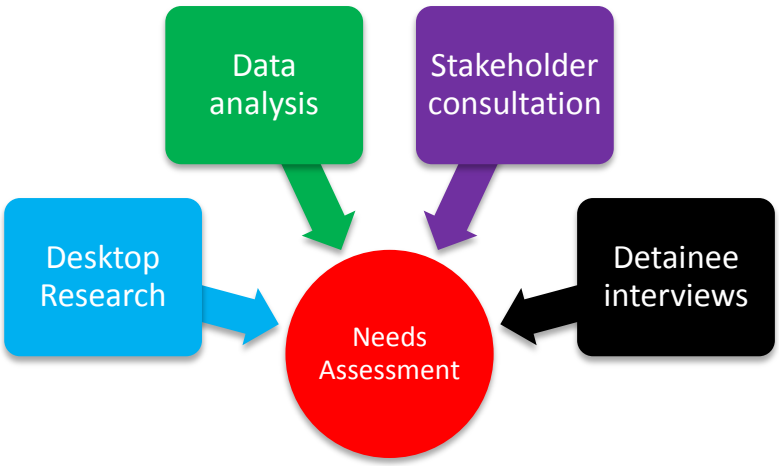
A total of 34 families were admitted in the six month period between September 2011 and March 2012. These families comprised 37 women, 10 men and 73 children. 32 of these children were aged under 5 years, 35 between 5 and11 years and six between 12 and 17 years old.

Cedars is also subject to independent inspection by the Chief Inspector of Prisons and the Children's Commissioner for England has a statutory right of access to Cedars (as well as family accommodation at Tinsley House.

Chapter 2: Methodology

Overview

This chapter sets out the four principal methods used in this study and discusses each in turn.



Desktop Research

Initially, it was intended to confine the scope of the review to the UK. However, there is relatively scarce literature relating to detainee health, so we extended our remit to include all English language documents.

In addition to searching journals for published research on detainee health, we utilised a range of approaches including the following key sources:

- Academic library holdings
- Policy and practice guidance documents
- Health observatories
- Internet searches

Analysis of monitoring data

G4S provided data about the number and demographic profile of detainees at the three centres, as well as information about the number of individuals subject to ACDT

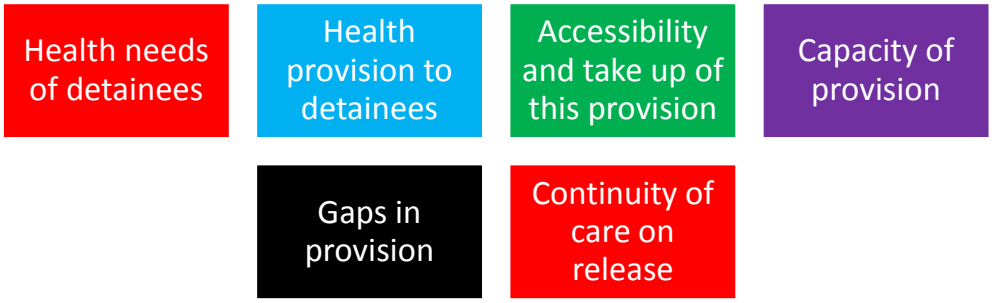
(Assessment, Care in Detention Teamwork) arrangements – normally applied to those at risk of self-harm.

SaxonBrook Medical supplied information relating to medical screening, prescribing and number of outpatient appointments (it was only possible to estimate these via transport arrangements).

Crawley Hospital supplied information about the number of hospital appointments for detainees from Brook and Tinsley.

The views of stakeholders

We undertook individual interviews with 26 key individuals from a range of organisations including G4S, SaxonBrook Medical, local health commissioners providers, and voluntary organisations concerned with the welfare of detainees. We interviewed twelve of these individuals face-to-face and the remaining fourteen by telephone. We also undertook a group interview with four individuals providing mental health and social care help. These interviews covered the following key issues:



Detainee interviews

Finally, we undertook interviews with a total of 33 detainees at Brook (21) and Tinsley (12) IRCs. We were unable to undertake interviews with detainees at Cedars owing to the very short time which families spend there prior to departure.

Information posters were translated into the 15 most common languages spoken by detainees. These posters emphasised the confidentiality of the interviews and that participation was entirely voluntary. Owing to the limited resources available for this study, interviews were only carried out in English and therefore only those with reasonable

proficiency in English were able to be interviewed. However, we did permit interviewees to have a friend present, either for emotional support or to help with interpreting.

These detainee interviews were all male and were aged between 18 and 59 years with an average (mean) age of 34 years. They came from 16 different countries with five interviewees from Afghanistan, four from Pakistan, three each from India, Jamaica and Nigeria and two from Bangladesh, Lebanon, Sri Lanka and Turkey.

They had been in continuous detention for between one day and two years with an average (median) period of 17 weeks. Ten of our cohort had been in detention for six months or more. Five of our detainees had been previously detained.

Approximately two fifths (14) of our cohort had previously been in the prison system and one in six (6) had had previous contact with mental health services.

Cedars

The very low use of Cedars meant that we were unable to conduct meaningful research at this facility since insufficient numbers of families had used services. The small number of detainees who did access the services were there for a very short of time which made access to researchers difficult. It was also considered an ethical issue as to whether detained families should be requested to participate in research in the 72 hours prior to their departure.

We did undertake interviews with professionals working at Cedars but redirected resources to our work at the two IRCs.

Chapter 3: A review of the literature

Introduction

This Chapter presents a summary of the available English-language literature on the health of detainees.

Although there are considerable bodies of research on prisoner health and the general health of migrants, there is very scarce published material on the health of people who are detained because of their immigration status.

Even within this limited material, there are a number of publications in medical journals which advocate against the principle of detention and its negative impact on health but which do not provide data beyond occasional anecdotes or case histories.

There is, however, a small body of evidence relating to the mental health of detainees. Since this issue was the priority area identified by the majority of interviewees consulted for this study, we will focus on the literature relating to the mental health of detainees in this chapter.

It should be borne in mind that much of this literature relates to detained immigrants in different countries where the buildings, nature and regimes of detention centres vary considerably from those in the UK.

The chapter concludes by commenting on the very sparse literature relating to the physical health needs of detainees.

Mental health

A number of studies seek to identify the rates of mental health problems amongst detainees. Different commentators explore different areas including:

- The prevalence of mental health problems amongst asylum seekers.
- The proportion of detainees with experience of torture who may be vulnerable to Post Traumatic Stress Disorder.
- The impact of detention on detainees' mental health.
- Particular concerns about the mental health of children in detention.

We will consider each of these four areas in turn.

Mental health problems amongst asylum seekers

Raphaely and O'Moore (2010) conducted an online survey advertised to key informants in the health and local authority sectors in the South East of England which was completed by 60 individuals. The survey respondents identified mental health as a significant problem for migrant populations with particular vulnerabilities among asylum seekers and refugees.

Jayaweera (2003) noted that there is limited data on migrants' health in the UK, particularly at a large-scale quantitative level with very few sources which distinguish between economically better-off and worse-off migrants. She noted that local studies in the UK and systematic reviews of studies across European countries report higher rates of depression and anxiety among asylum seekers and refugees compared to the mainstream population or other migrant categories.

Cohen (2008) examined the incidence of suicide and self-harm among asylum seekers in the UK – both those in detention and the community. He analysed 231 incidents of self-harm requiring medical treatment in Immigration Removal Centres recorded by the Home Office in the 12 month period up to 31st of March 2006. He claims that a greater proportion of detainees self-harm than prisoners held in the justice system.

Post Traumatic Stress Disorder (PTSD)

Athwal & Bourne (2007) discuss the vulnerability of asylum seekers to self-harm, particularly those who have escaped torture and oppression. Arnold, (2007) claims that detainees with evidence of torture and PTSD are referred for help but do not receive it.

Cohen (2008), Mares et al. (2002) and Salinsky and Dell (2001) all discuss the needs of detainees who have been tortured, stating that in addition to PTSD, the majority show symptoms of a wide range of mental illnesses.

Impact of detention

There are a small number of, mainly Australian, studies into the impact of detention on mental health.

Green and Eagar (2010) undertook an analysis of the health records of 720 of the 7375 people in detention in Australia in the 12 month period up to 30th of June 2006. They found that people detained for longer than 24 months have particularly poor health, both mental and physical. The proportion of people with at least one mental health diagnosis

was related to time spent in detention. The estimated proportion of those with a new mental health diagnosis during the year varied from <1% in the group detained for less than three months to >27% of those in detention for longer than 24 months.

Steel et al. (2006) applied symptom questionnaires to a study group of 241 Sabaean-Mandaeans (commonly known as Mandaeans), a small pre-Christian sect of approximately 100,000 people originating mainly from Iran and Iraq, of whom 150 were detained on arrival in Australia. The study suggested that prolonged detention contributed substantially to the risk of on-going depression, PTSD and mental health-related disability in refugees, even when controlling for other variables typically identified as risk factors (including being female, older, having past traumas and being separated from family). The study also suggested that prolonged detention exerted a long-term impact on the psychological well-being of detainees who reported persistent sadness, hopelessness, intrusive memories and attacks of anger which were related to the length of detention.

A similar set of findings was reported by Keller and colleagues (2003) in a study of 70 asylum seekers detained in the US states of New York, New Jersey and Pennsylvania. The study relied on two self-report questionnaires. At baseline, 54 (77%) participants had clinically significant symptoms of anxiety, 60 (86%) of depression, and 35 (50%) of post-traumatic stress disorder; all symptoms were significantly correlated with length of detention. At follow-up, participants who had been released had marked reductions in all psychological symptoms, but those still detained were more distressed than at baseline.

Ichikawa and colleagues (2006) also reported along similar lines in a small-scale study of 55 Afghan asylum seekers in Japan. Although only 18 of this sample were kept in detention (for a median of seven months), they did display a higher symptom score for depression, anxiety and PTSD.

Children in detention

Fekete (2007) reviewed a variety of secondary sources across Europe to examine the health impact of detention on children. She reports that the long term consequences of detention include depression, behavioural changes and undermining of the ability to learn. She concludes that:

"detention is an extremely stressful experience for any child but for children with earlier experiences of trauma and loss, it can also be a cause of re-traumatisation".

Lorek et al. (2009) reported on a study of 24 children detained in a UK immigration centre. The children (aged between three months to 17 years) were assessed by a paediatrician and/or psychologist using semi-structured clinical interviews after being referred by a legal charity. All 11 children who received a psychological assessment reported symptoms of depression and anxiety. The authors concluded:

" The traumatic experience of detention itself also has implications for the sizeable proportion of psychologically distressed children who are eventually released from detention and expected to successfully reintegrate into British society; while those children who are deported are returned with increased vulnerability to future stressors."

Mares and colleagues (2002) wrote a paper based on their observations at visits to detention centres in Australia. They concluded that parents and children in immigration detention were often vulnerable to mental health problems before they reached Australia but that experiences in prolonged detention added to their burden of trauma which they claimed had an impact not only on the individuals but on the family process itself. They felt that detention profoundly undermined the parental role, rendered the parent impotent and left the children without protection or comfort in an environment where the basic needs of safe play and education were unmet. The authors concluded that psychiatrists had a role in advocating for appropriate treatment of both parents and children.

The literature relating to the health of children in detention is particularly limited.

Physical health

Fekete (2007), cited above, states that some of the side-effects experienced by detained children which were documented by health professionals include: sleeplessness and nightmares; bedwetting; weight loss; skin complaints and persistent respiratory conditions.

Green and Eager (2010), also cited above, found that the most common physical problems for those detained for more than two years in Australia included dental and musculoskeletal problems as well as lacerations.

NICE (2012) issued guidance earlier this year on identifying and managing tuberculosis in hard to reach groups, recommending that screening should be a priority for people born in countries with an incidence of more than 150 per hundred thousand per year.

Conclusion

We conclude this brief literature review by looking at two studies about how migrants access healthcare in the hope that some of the findings will be useful in our needs assessments of the three immigration facilities.

Dorn and colleagues (2011) undertook a study of 224 male migrants who arrived at a Dutch detention centre between May and July 2008. Only half of the 122 respondents who met the study's criteria knew how to access healthcare in the Netherlands.

Priebe et al (2011) investigated good practice in health care for migrants by surveying nine primary care practices, three accident and emergency hospital departments and three mental-health services in each of 16 European countries. The authors organised their findings by identifying eight key problems:

1. language barriers
2. difficulties in arranging care for migrants without health care coverage
3. social deprivation/traumatic experiences
4. lack of familiarity with health care system
5. cultural differences
6. different understandings of illness and treatment
7. negative attitudes among staff and patients
8. lack of access to medical history

and seven components of good practice:

1. Organisational flexibility with sufficient time and resources
2. Good interpreting services
3. Working with families and social services
4. Cultural awareness of staff
5. Educational programs of information material for migrants
6. Positive and stable relationships with staff
7. Clear guidelines on care entitlement

Regrettably, the scarcity of literature relating to the health of detained asylum seekers means that it has not been possible to establish a robust evidence base as a context for this health needs assessment. However, the findings regarding the impact of detention on mental health do influence our recommendations in the final chapter.

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Chapter 4: Physical health

Introduction

This chapter starts by describing the service provided, goes on to analyse data to give an indication of the range of physical needs and concludes with the views of professionals and detainees on the appropriateness of the services provided.

Service provided

SaxonBrook Medical provided the health care services at all three facilities until 1 May 2012 when G4S took the service in-house and existing staff were transferred over under TUPE arrangements.

The healthcare team consists of the following staff:

Brook House

- General Practitioner available six hours per day on weekdays and four hours per day on weekends.
- Two full-time Registered General Nurses (daytime)
- One Registered Mental Nurse
- One health care assistant
- There are two registered nurses available at night.

Tinsley House

- General Practitioner available four hours per day on weekdays and two hours per day on weekends.
- One full-time Registered General Nurses (daytime)
- Registered Mental Nurse cover on demand (there was a vacant post at the time of this needs assessment)
- One registered nurse available at night.

There were unfilled RMN posts at the time of this study. These posts had been vacant for some time, in part because of delays in gaining CRB checks for staff who had then found alternative employment in the intervening period.

In addition, a dentist conducts a screening session for those with emergency dental needs in a 90 minute session once a fortnight. The session takes place at Brook House and Tinsley detainees are transported there as required. The dentist prescribes antibiotics when required and makes referral to emergency dental services when appropriate. There are no dental facilities at either IRC to enable any dental interventions.

An optician also attends Brook House on average once every six weeks.

Cedars

The provision at Cedars is for a doctor to be available two hours per day (1 hour at weekends) and a nurse to be on-site day and night. During the period of this needs assessment, there were frequently times when there were no families resident at Cedars and therefore staff were re-deployed to the two IRCs.

Accessing healthcare

All newly arrived detainees are provided with an initial screening within two hours of arrival in line with the Detention Services Operating Standards[1].

As part of the screening a medical history is taken seeking to identify any chronic diseases and current symptoms and also questions about any drug, alcohol or tobacco use are raised. Neither Tinsley House nor Brook House accept detainees in need of medical care for their dependence on drugs or alcohol. If such detainees are admitted, they are referred to other Immigration Removal Centres with necessary provision immediately. The screening also asks about experience of mental health problems and any contact with helping services, a self-harm risk assessment is always undertaken. Detainees are also specifically asked about any experiences of torture or trauma. The screening also tries to identify any learning disabilities and establish risk of HIV. If risk of HIV is established, detainees are offered the chance of being tested.

If detainees arrive in the middle of the night and state that they have no pressing medical problems, the screening process is shortened and they are invited to make contact with the doctor or nurse the following day, if needed.

All detainees are informed at their screening on how to access healthcare which they can do by presenting themselves at the medical rooms between 9:30-11:30 AM seven days per

[1] The official healthcare reports provided by G4S to UKBA for April and May 2012 recorded that all 1113 new receptions into Brook and Tinsley in that period were screened within two hours of arrival.

week. Outside of these hours they can knock on the medical room door or ask Detention Custody Officers to help them to access medical help.

A similar screening service is provided at Cedars although full medical records will already have been received by medical staff who will have made plans to address any health care needs both during the 72 hours of their stay and on return to their country of removal/origin.

Service

The healthcare service is similar to that provided by a typical GP with a full prescribing service and referral to secondary care when needed. The healthcare service has the capacity to administer ECGs on-site and gives antimalarial medication to those eligible (detainees with suppressed immune systems, pregnant detainees and children under the age of five years).

Since detainees' length of stay is almost always uncertain on admission (scheduled removal dates are often changed, and removal decisions altered on appeal etc.), referrals to secondary care are made on assessment of medical need and do not take into account the fact that the individual may shortly be leaving the UK or discharged to the community in another part of the country[2].

Interventions

SaxonBrook provided information on the number of doctor consultations provided in the calendar year of 2011. The data system had some limitations with patients seen for more than one condition at the same time counted separately for each condition, as well as for a number of administrative interventions.

There were a total of 10,264 recorded consultations on 1782 different patients who received between 1 and 73 consultations each.

346 detainees received 10 or more consultations each.

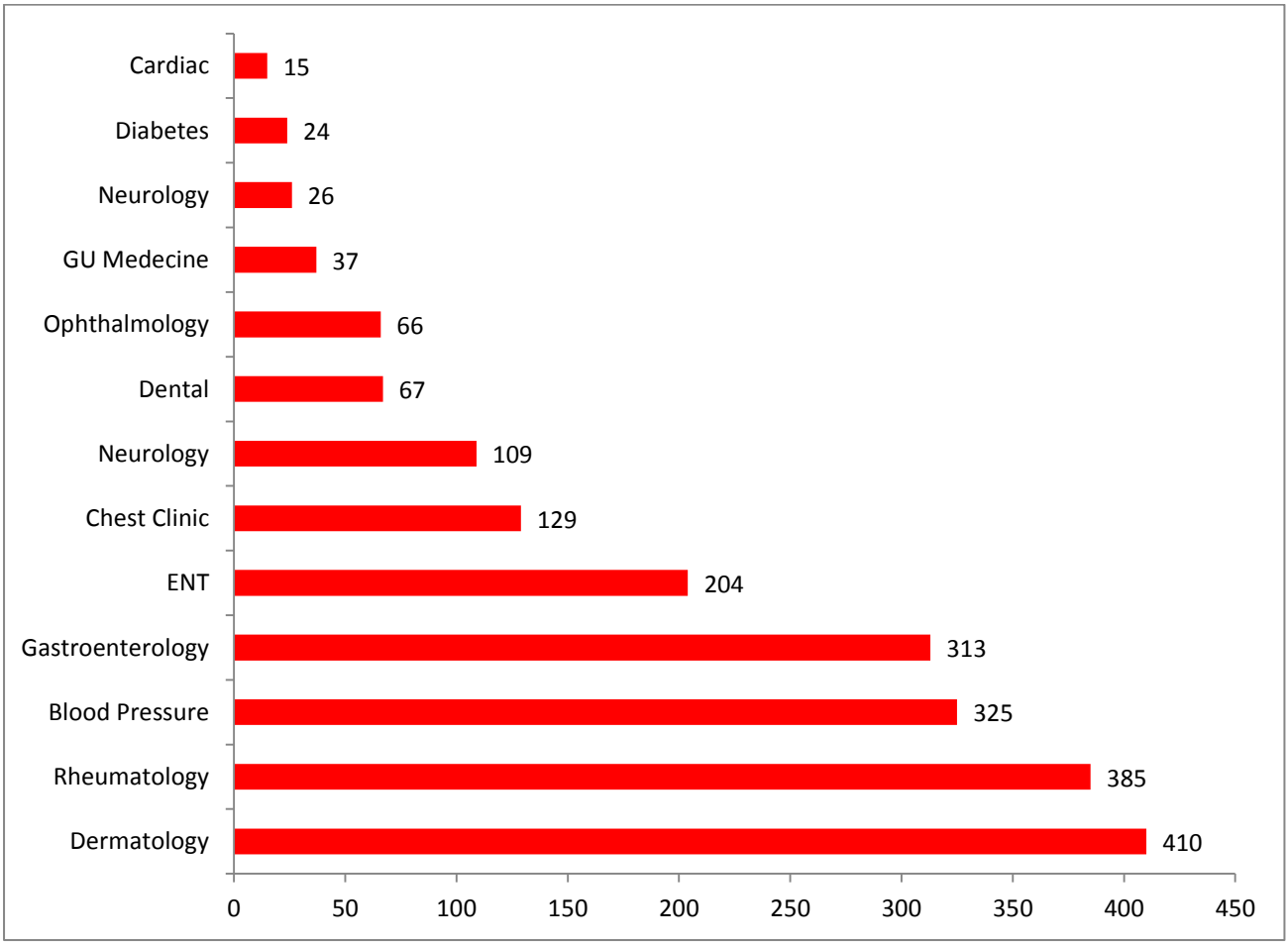
Just 80 of these consultations were provided to female detainees. Unfortunately no information was available in the majority (48) of these cases. In the remaining 32 consultations, five detainees were seen regarding their blood pressure or mental health

[2] Detention Services Order 7/2012 issued in March 2012 states that ***"Every effort should be made to keep external medical appointments made for detainees"***.

disorder, three in relation to rheumatology, and two each in relation to dermatology, antenatal or chest care. Female detainees have the right to request seeing a female doctor, but it is not clear whether detainees are made aware of this right or have made this request. However, it should be noted that women detainees make up a very small proportion of the population at Tinsley (2% of 2011 receptions).

The most commonly recorded reason for a consultation with a male detainee was a mental health concern (more details are given in the following chapter). Figure 11 provides a breakdown of the reason for all other consultations[3]

Figure 11 Reason for consultation for male detainees



In addition, six detainees were recorded as being HIV positive, six received a consultation around tuberculosis and six were immunised against TB.

SaxonBrook Medical also provided information on the prescriptions made for the calendar year of 2011. Unfortunately, these data are difficult to interpret. This is mainly because a

[3] Only conditions which were recorded on at least 10 occasions are included.

considerable number of medications are dispensed on a dose-by-dose basis so that consumption can be observed. The data does not differentiate between one prescription comprising sufficient medication for one month which a detainee is allowed to have in his care and self-administer and the equivalent 90 prescriptions of another medication which has to be the dispensed three times per day over the same one month period.

Nevertheless, it was possible to ascertain that a total of 960 different detainees received 4354 prescriptions of different medications during 2011.

Dr Thomas from SaxonBrook kindly undertook additional analysis to estimate the total number of doses of different categories of drugs prescribed and an estimate of the average number of individuals being prescribed such drugs at any one time. This information was only available for Brook House and we have not been able to verify the methodology. Dr Thomas provided the information in a mixed format (including both specific medications e.g. clonazepam, and types of drugs e.g. beta blockers) which we have converted into BNF Categories. Medication prescribed for mental health conditions are omitted and presented in the next chapter. Figure 12 shows the conditions for which medication was most commonly prescribed at Brook House in 2011, the chart shows total number of doses.

Figure 12 Most commonly prescribed medications by type – Brook House 2011

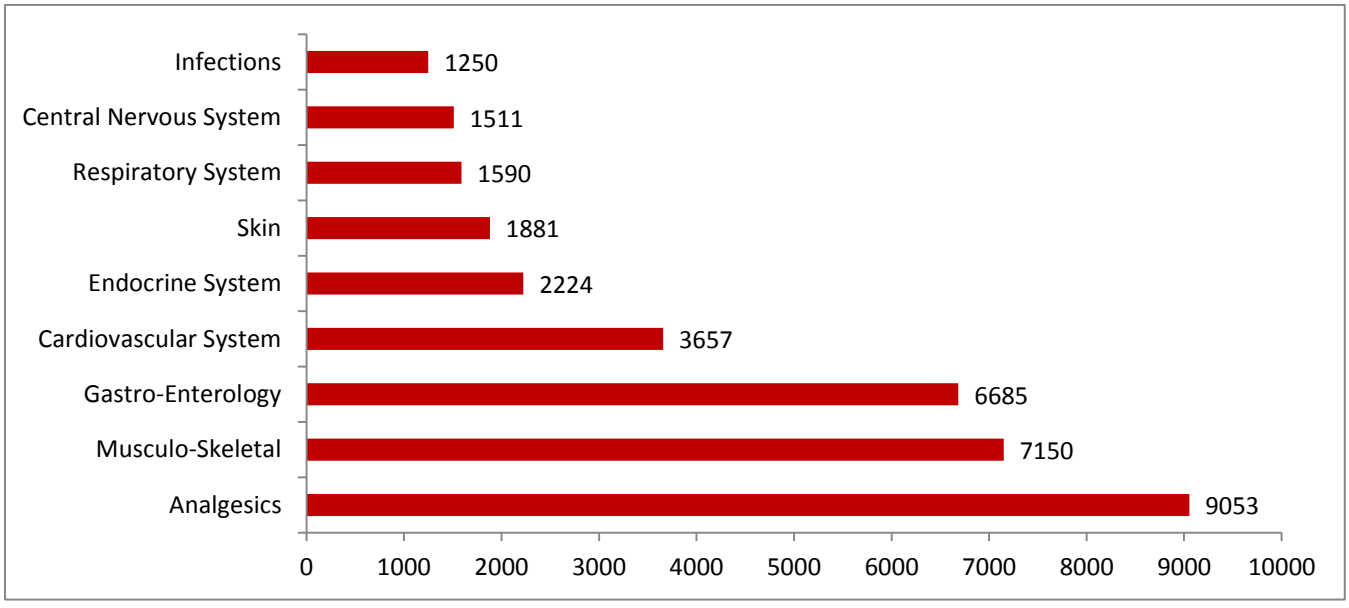
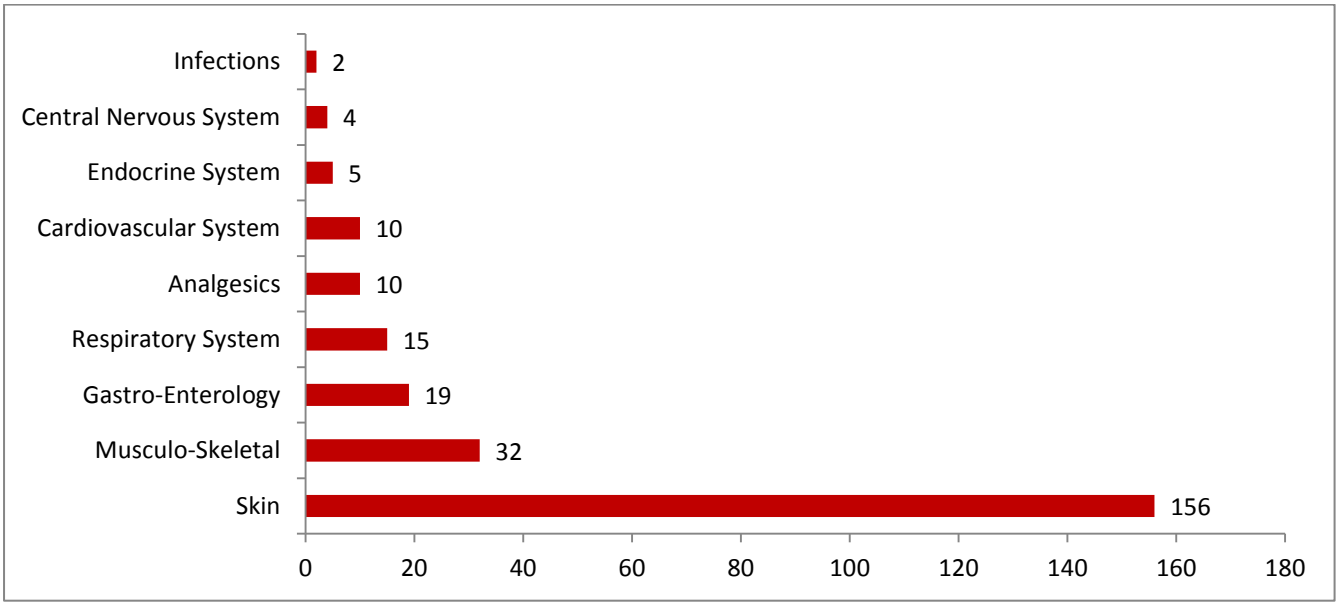


Figure 13 shows Dr Thomas estimate of the average number of detainees receiving treatment for these categories of medication at any one time in Brook House in 2001.

Figure 13 Average Number of Detainees receiving medication by category



Opticians

The visiting optician saw 71 detainees at Brook House in the last nine months of 2011 of whom 58 were prescribed glasses. During the same time period, just three detainees at Tinsley saw the optician, all of whom were prescribed glasses.

In addition a total of 90 sets of reading glasses were dispensed across both IRCs in 2011.

Hospital appointments

The only source of data from the IRCs for hospital appointments made for detainees was information about transport requests to enable detainees to be escorted to their appointments.

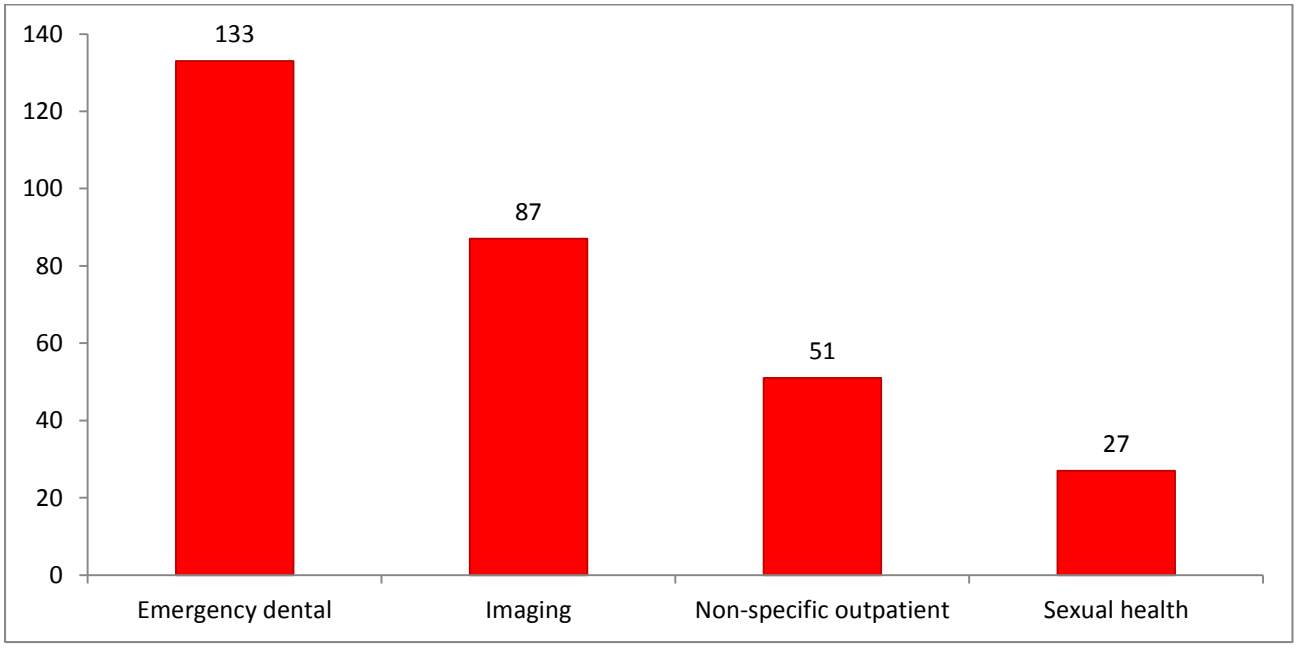
A total of 542 hospital appointments where transport was requested were booked between 1 March 2011 and 29 February 2012. Sixty four of these appointments were subsequently cancelled because the detainee had either been removed, transferred to another IRC or discharged back into the community. 29 of these cancellations concerned appointments at East Surrey Hospital and 24 at Crawley Hospital.

Of the remaining 478 appointments, 80 were classified as imperative, 367 as important and 31 as routine.

Just over two fifths (42%) of these appointments were made at the East Surrey Hospital, slightly more than one quarter (26%) at Crawley Hospital and a 10th for the visiting dentist who holds a fortnightly surgery at Brook House.

Figure 14 shows the main departments to which these hospital appointments were made.

Figure 14: Departments for hospital appointments[4]



"Imaging" includes x-ray (59), diagnostic imaging (16), and ultrasound (12).

"Sexual health" includes detainees referred for HIV services.

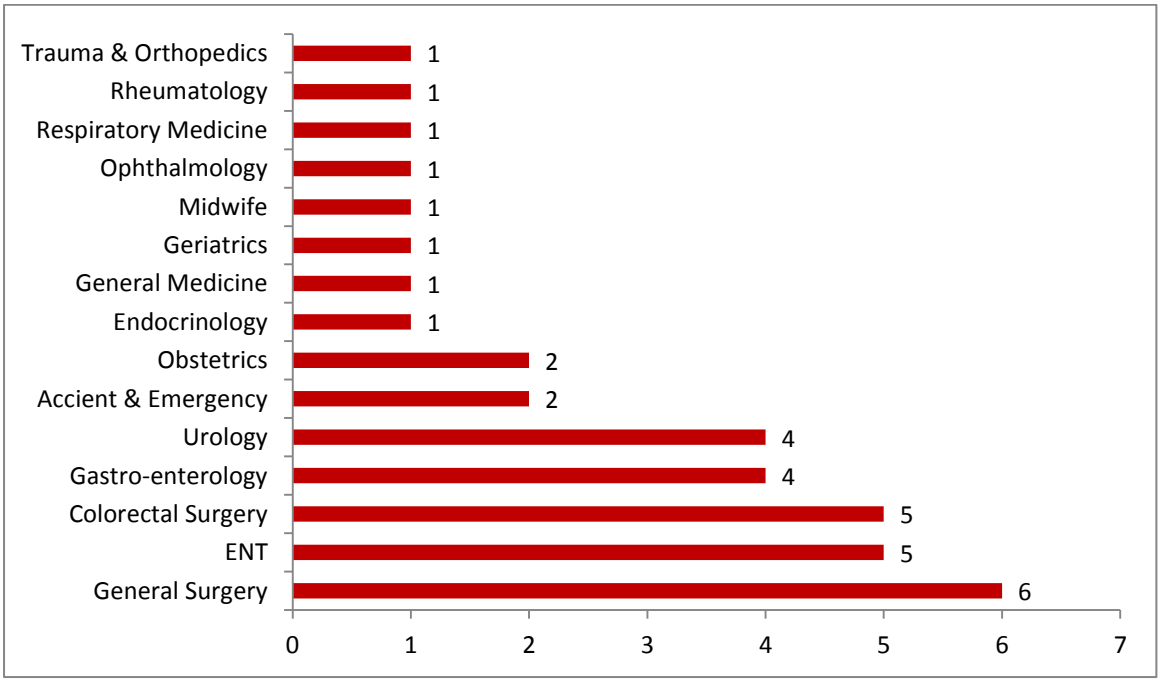
In interview, the manager of the sexual health service (which until recently also delivered HIV services) stated that detainees attending the service often either did not attend or were very late for appointments.

Attempts were made to correlate this information with information from West Sussex PCT. The PCT was able to provide information on admissions to Surrey and Sussex Hospital, but not out-patient appointments. The data source was regarded as problematic, the PCT provided data on all admissions from the postcode covering Tinsley and Brook Houses with the disclaimer that postcodes are not always recorded. However, the postcode covers the Gatwick Airport Perimeter Road, and does not appear to cover any other residential properties; therefore the data provided is highly likely to relate to Tinsley and Brook detainees only.

[4] Only departments for which at least 10 appointments were made are shown.

Sixteen detainees were recorded as being admitted to the hospital in the financial year 2010-11and 20 in the following year. Figure 15 shows the department of admission for both years combined.

Figure 15 Detainee admissions to Surrey & Sussex 2010-12 (n = 36)



Professional views

There was a strong consensus amongst all professional interviewees that the physical healthcare provision was of high and consistent quality. There was an acknowledgement that any previous difficulties had been addressed. An in-house audit commissioned by UKBA had found some issues relating to secondary prescribing but these were described as having been "long resolved".

Previous difficulties around securing HIV medication for removed detainees to cover their first 12 weeks back in their home country had also been resolved.

The provision of anti-malarial medication was also working smoothly although some interviewees thought it should be made available to a wider group of detainees (currently policy dictates that it should be provided only to those whose immune system is suppressed, those who are pregnant and those aged under five years).

Some specific issues were identified as areas for improvement:

- Owing to a lack of medical bedspaces, individuals with minor contagious or infectious diseases (such as scabies or mumps) are isolated in the Care and Separation Unit (CSU). The CSU is designed primarily to hold detainees who do not comply with IRC rules and the regime involves being locked in a cell for 23 hours per day. Therefore detainees with these conditions unfortunately experience a punishment regime while they present a health risk to other detainees. The same treatment is accorded to those who are suspected of having Tuberculosis.
- It is difficult for detainees with mobility problems to move around the centres, although a small number of rooms have been adapted, access to classrooms, visit areas and the medical centre at Brook House is problematic.
- Detainees who require comprehensive but not emergency dental treatment – such as work on roots, broken dentures – do not receive this as it does not come within the terms of the contract with the provider of dental treatment. This represents real difficulties for some detainees, particularly if they remain in the detention system for a period of months, and differs from the dental treatment provided in the community by the NHS.
- The sexual health (and HIV) service provider had found it difficult to form an effective working relationship with the IRCs and to get a formal Service Level Agreement drawn up and agreed. She had suggested the possibility of providing an in-reach service on a pilot basis but had received no encouragement from the IRCs. The service is currently being re-configured into two separate functions (sexual health and HIV) and has been re-tendered so this offer is no longer available in its present form.

The views of detainees

All the detainee interviewees were asked whether they had received a medical screening on arrival and about their experience of healthcare whilst in detention in addition to being given the opportunity to suggest improvements to the health care system.

All 33 interviewees had been screened on arrival and a large majority (28) felt that the screening had been appropriate and undertaken with respect. The other five interviewees either could not remember or made minor negative comments.

From our analysis of the interviews, we have highlighted four key issues in relation to physical healthcare:

- Access to treatment
- Appropriateness of treatment
- Food and exercise
- Dental services

We will treat each subject in turn below.

Access to treatment

A large majority of interviewees stated that it was a straightforward process to access help from the doctors or nurses. However, two interviewees stated that nurses on the wing could be rude and did not provide easy access to healthcare. One interviewee stated that sometimes there is a queue and another that it is difficult to see a doctor after 12 o'clock midday.

A further interviewee felt that he received good and prompt treatment for asthma following difficulties in the middle of the night but that it had initially proved difficult to access healthcare because the Detention and Custody Officers on duty did not want to make a referral.

Appropriateness of treatment

There was a much greater divergence of opinion on the quality and appropriateness of the treatment provided.

Four interviewees stated that they had had problems in getting appropriate medication prescribed. In three cases, the doctor had agreed to continue an existing prescription but the medication concerned had not been available in the IRC for between 5 - 10 days. There were also three examples of existing medication being prescribed immediately with no difficulties.

Two interviewees complained about the need to pick up medication for every dose three times per day; in both cases interviewees had mobility problems which aggravated the difficulties in attending healthcare on such a regular basis.

Two other interviewees felt that there had been unreasonable delays in providing treatment for a broken/badly bruised leg and kidney stones respectively. Detention and Custody Officers agreed that treatment had been too slow in the case of the broken/bruised leg.

A total of four interviewees felt that access to secondary care in hospital had been slow although a larger number (six) acknowledged that it took time to access such services in the community as well.

It appeared that formal interpreting services were rarely used with detainees mainly providing this service for each other.

Overall, 15 interviewees reported that they were generally happy with the quality of healthcare provided as opposed to eight who were not. Seven of these eight complained that healthcare provision mainly consisted of prescribing paracetamol for a range of complaints. The other 10 interviewees did not express an opinion either way, mainly because they had had very little contact with healthcare services.

Physical exercise and diet

Although four interviewees commented positively about the gym, seven individuals complained about limited access. They commented negatively about the range and quality of resources with two interviewees stating that there were greater exercise options in prison. Four interviewees would also have liked the opportunity to exercise outside from more than one hour per day.

We were informed by UKBA that the gym provision was in the process of being improved during the course of our study and is now open from 8:30 a.m. to 9:00 p.m. We were also informed that detainees are not restricted to one hour's outside exercise per day, despite the perceptions of some of our interviewees.

Nine interviewees complained about the quality and variety of the food provided, with three individuals stating that there was too much food characteristic of the Indian Sub-Continent.

Dentistry

Interviewees who had had contact with the dentistry service were mainly pleased with the service. However, four detainees complained about the wait for a service (between three weeks and three months) and one was disappointed that he was not eligible for the dental work he desired.

One interviewee was similarly pleased with the service from the optician but noted that he had to wait six weeks.

Other

The health promotion work in relation to smoking cessation appeared to be effective with three of our interviewees mentioning the service and two using nicotine patches at the time of interview.

One interviewee noted that he had been placed in isolation in the CSU for eleven days because he was suspected of having tuberculosis, which proved not to be the case.

Gaps in provision

It is not clear why detainees may access all healthcare services in the same way as UK citizens with the exception of dental services where only emergency work is sanctioned.

Chapter 5: Mental Health

Introduction

Mental health services at the IRCs are primarily provided by the Registered Mental Nurse (RMN) who is part of the Healthcare team.

The service provided

The RMN provides one-to-one advice and support to detainees who access the service in the same way as general healthcare – by coming to the healthcare offices or being referred by other members of staff.

If Detention and Custody Officers or any other members of staff are concerned that a detainee may self-harm, they refer that detainee for an assessment and support under the provisions of the Assessment Care in Detention and Teamwork (ACDT) strategy, itself based on the prison-service ACCT (Assessment Care in ***Custody*** and Teamwork) approach.

Since there was only one RMN in post working across all three facilities at the time of this study (a second RMN was providing an additional 12.5 hours per week), it was not possible to meet the level of expressed need.

All professional and detainee interviewees agreed that there was insufficient provision to meet the mental health needs of detainees.

There was additional, but limited provision from a number of other sources:

A consultant psychologist (a trauma specialist) from Sussex Partnership Trust attended Tinsley for half a day per week where she saw two to three detainees to help them cope with a variety of trauma including experiences of torture.

A consultant psychiatrist based at Crawley Community Mental Health Team provides two half days of psychiatric input at Brook and Tinsley per week. The service consisted of assessments and reviewing medication, it was not possible to provide treatment within this limited provision.

The Samaritans attend Tinsley for one session once a fortnight (recently increased from once per month) to provide general advice and support to detainees. The service had also

been available at Brook but had been discontinued because of disagreements over the referral process. The Samaritans preferred to operate on an open access basis, but G4S had required detainees to make a formal application. At the time of this study, it had just been negotiated to re-open an open access service based in the library at Brook House for two hours once a month with the possibility of doubling this if things ran smoothly.

The Gatwick Detainee Welfare Group provides a visiting service to individual detainees on a weekly basis to provide support and human contact in addition to a range of advocacy and welfare services.

G4S also provides one welfare officer at each of Brook and Tinsley to provide advice and support.

Interventions

In 2011, SaxonBrook Medical doctors delivered 658 consultations related to mental health disorders to a total of 371 different detainees with each detainee receiving between one and eleven consultations. Five of the 32 consultations provided to female detainees where the reason for the consultation was recorded were for mental health disorders.

Dr Thomas undertook an analysis of medications prescribed (see this section in preceding chapter), the details of which are presented in Figures 16 and 17 below:

Figure 16 Total number of doses of medication prescribed for mental health disorders by category

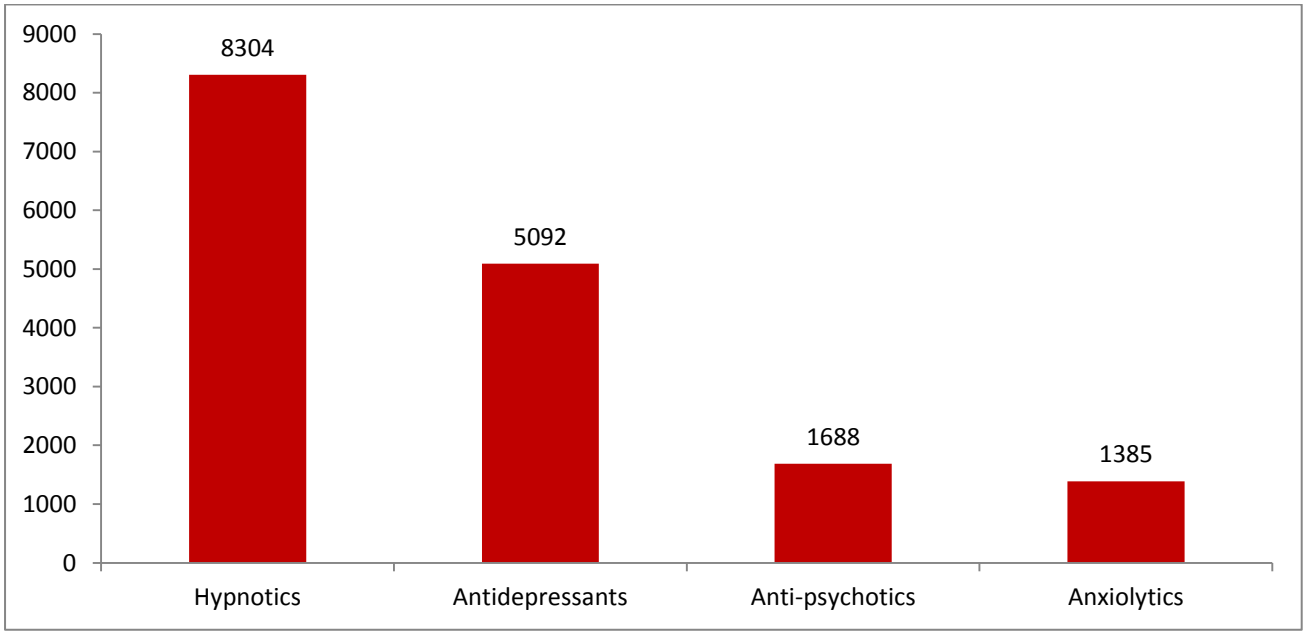
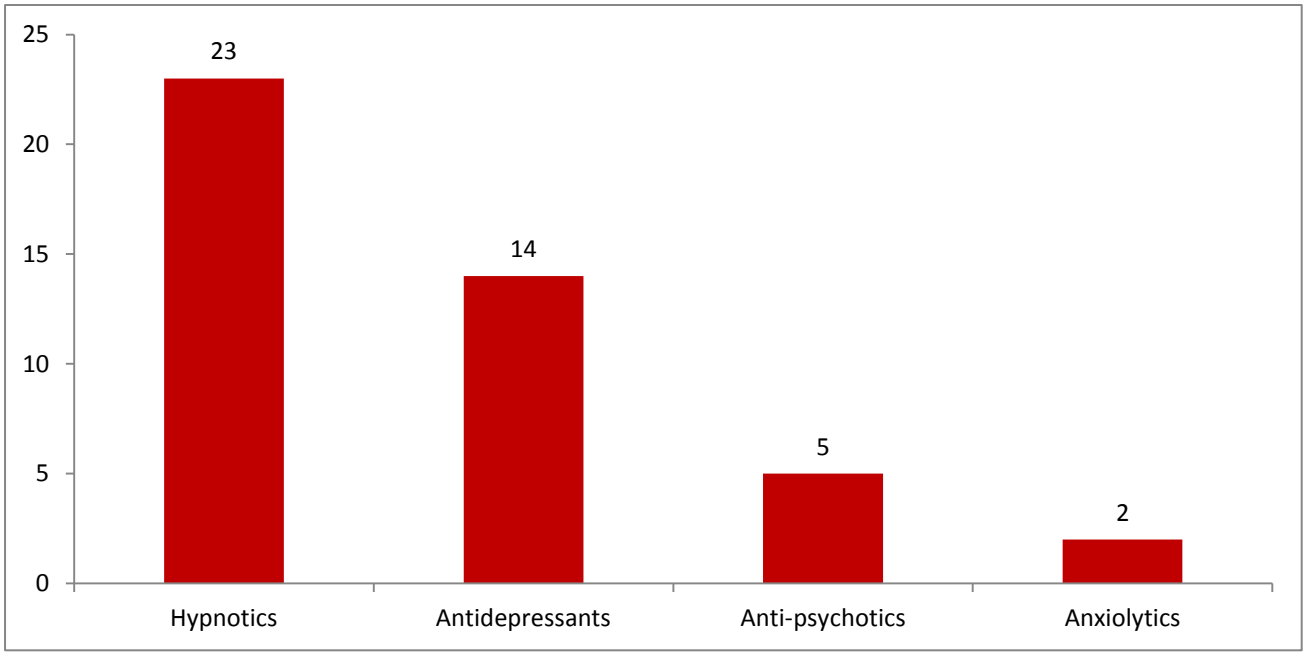


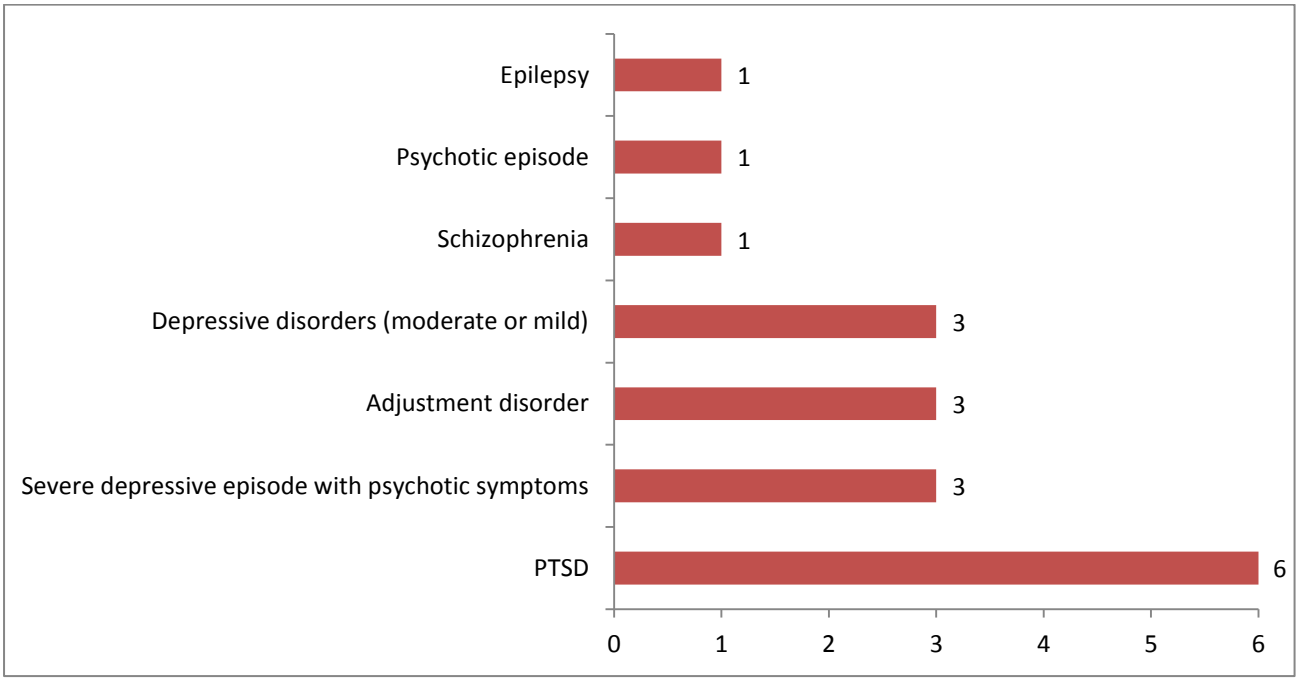
Figure 17 Categories of medication prescribed for mental health disorders (estimated number of detainees prescribed at any time)



A total of 25 detainees were seen by the consultant psychiatrist in the eight month period from 1 May to 21 December 2011, at both Brook and Tinsley IRCs. One detainee received three sessions, two received two sessions and all the rest received a single session. This is the equivalent of 38 detainees annually.

Dr Spoto, Consultant Psychiatrist based at Crawley Community Mental Health Team, also provided us with a report on a pilot service to Brook House which was provided in 2009 – 2010. The service consisted of weekly visits by Dr Spoto who saw a total of 22 patients whom he diagnosed as having the following conditions:

Figure 18 Diagnosed conditions of pilot psychiatric service to Brook House



There were also four detainees who are diagnosed as having "mental and behavioural disorder due to drugs and alcohol – abstinent, but in a protected environment".

The report noted that hospital treatment was recommended in three cases and suspected to be necessary at some indeterminate point in the future in a further three cases. Immediate release was recommended in five cases where reunion with the family was deemed to assist recovery and seem to be a desirable alternative.

Gatwick Detainees Welfare Group visited 195 detainees in Brook House and 97 at Tinsley House (the last year for which figures are currently available).

The Samaritans had had contact with 138 detainees from 35 countries at Tinsley House in the most recent year covered by their annual report.

The views of professionals

All the professionals interviewed were dissatisfied with the capacity and quality of mental health provision. Their views centred around six key issues which are discussed in more detail below:

1. The impact of detention on mental health.
2. The limited range of services available.
3. The lack of any health care beds for detainees with serious mental health problems.
4. The poor quality of care pathways with community and in-patient services.
5. The lack of mental health awareness training for detention staff.
6. Concerns over whether some detainees were fit for detention.

The impact of detention

Several interviewees felt that little was done to address the impact of detention on detainees' mental health. Our review of the literature suggests that the experience of indeterminate detention combined with the prospect of being returned against one's will has a negative impact on many detainees' mental health and that these negative effects increase the longer that a person is detained.

Many interviewees expressed a similar view and felt that there was not sufficient provision aimed at supporting detainees to cope with the experience of detention and associated depression, anxiety and other mental health concerns.

SaxonBrook Medical provided information on the validated length of stay on the 57 detainees at Brook House who had been identified as having a mental health disorder at their induction screening in 2011. The average length of stay of this cohort was 69 days compared to 22 days for all admissions to Brook and Tinsley in 2011.

This information suggests that not only does an extended stay impact on detainees' mental health, but that those who are admitted with mental health concerns are doubly vulnerable because they tend to stay in detention for longer. Interviewees speculated that the reason for this might be that the legal issues regarding the removal of these individuals were more complex owing to their mental health problems.

SaxonBrook interviewees stated that they had developed a number of different screening tools but it was not possible for us to test the effectiveness of these. It is clear that there are a number of issues to bear in mind when screening the mental health of detainees on reception:

- Some detainees may be reluctant to disclose mental health issues
- Some detainees will come from cultures with very different concepts of mental and emotional well-being
- For many detainees, there will be a significant language barrier.
- Some detainees may have had no previous contact with health services in order to avoid detection by immigration services.
- Some detainees may wish to exaggerate any mental health condition in order to support their legal case against removal.

Some interviewees mentioned that the services provided by the Gatwick Detainee Welfare Group and the Samaritans provided good support for detainees which enhanced their emotional resilience. Four interviewees mentioned that more use could be made of online support services since detainees had good access to the Internet. Two interviewees mentioned that websites which offer advice and support for those struggling with depression and thoughts of self-harm are sometimes inadvertently blocked out of a fear that they are sites which are promoting self-harm or suicide.

Although several interviewees praised the quality of the service provided by the SaxonBrook RMNs, they all agreed that the service was under resourced. There was also general disquiet expressed at the lack of any other interventions with the exception of the very small number of detainees who received a service from the consultant psychologist.

Interviewees noted that there were no psychiatric interventions apart from a review of medication and some prescribing. The lack of any individual-or group-based talking therapies was cited by most interviewees.

Several interviewees cited the difficulties of detainees suffering from Post-Traumatic Stress Disorder, many of whom were unable to access an appropriate service.

It should be made clear that detainees are entitled to the same standard of care as normally provided by the NHS for both their physical and mental health needs.

Lack of beds

The lack of any health care beds for detainees with physical or mental health problems was widely regarded as extremely problematic. Detainees about whom there were serious concerns of self-harm and who, therefore, could not be managed by mainstream ACDT procedures in general accommodation were effectively placed into solitary confinement in the Care and Separation Unit. The lack of medical support combined with being locked in a

cell for 23 hours a day was generally agreed to exacerbate the poor mental health of most detainees. The fact that the two observations cells (with Perspex viewing panels from the waist up) faced each other was also regarded as unhelpful.

The G4S staff responsible for Safeguarding and ACDT procedures both stated that the number of ACDT cases had been increasing steadily over the past 18 month period.

Care pathways

Again, there was a consensus that where detainees had serious mental health problems and needed to be assessed for possible compulsory admission to in-patient care under the provisions of section 48 of the Mental Health Act, it proved very difficult to implement these procedures.

Interviewees reported that it frequently took between seven days and three weeks to organise the successful admission of a detainee.

There was agreement that one of the causes of these delays had been disputes about which Primary Care Trust should bear the costs of in-patient treatment. Although policy states that the PCT in whose location the treatment unit is situated pays, this has been contested at times.

Commissioners, managers and clinicians from community mental health services expressed frustration at the difficulty in organising effective care pathways with the IRCs although all believed that such pathways could easily be established provided that three key criteria were met:

1. An agreement about funding responsibilities.
2. Greater capacity of mental health provision within the IRCs.
3. Improved lines of communication.

All these interviewees expressed a clear commitment to providing a mental health service to all three facilities and felt that the quality of service provision could be significantly improved by the effective collaboration of IRC and community mental health services.

IRC interviewees were equally frustrated at the lack of clear pathways.

Interviewees from both parties agreed that care pathways would not be difficult to construct once better communication was established.

Mental health awareness training

Once again, there was widespread agreement about the importance of front line G4S staff receiving basic mental health awareness training to help them deliver an appropriate service to the high proportion of detainees who experienced mental and emotional health problems. This view was very much shared by the Detention and Custody Officers (DCOs) we interviewed.

All DCOs do receive mental health awareness training as part of the ACDT mandatory training but this is as part of their induction process and appears not to have influenced the work practices of the DCOs we interviewed.

Even the DCOs we interviewed who routinely worked on the CSU had received no additional training on how to deal with this client group many of whom had significant mental health problems. Several staff demonstrated a clear commitment to the detainees in their care and were trying to provide a helpful service. However, without any understanding of the problems faced by detainees, this proved very difficult to achieve in practice.

There would also be value in such training for staff's own support needs since they routinely work long hours in a stressful environment.

Fit for detention?

Seven interviewees questioned whether there were regularly individuals detained at Brook and Tinsley who did not comply with the UKBA Enforcement Instructions and Guidance:

"The following are normally considered suitable for detention in only very exceptional circumstances, whether in dedicated immigration detention accommodation or prisons: … those suffering serious mental illness which cannot be satisfactorily managed within detention"

They felt that there should be clearer and more transparent procedures for assessment in such cases.

We are not able to comment on the validity of these claims but have included the views since they were raised by several interviewees despite not being a topic within our semi-structured interview schedule.

The views of detainees

Fewer detainees had views about services for mental health compared to those for physical well-being for the simple reason that the vast majority had had no contact with the limited helping services.

A substantial minority (10) of interviewees commented that they struggled with feeling depressed and had difficulties with sleeping or general mood but all attributed these feelings solely to the experience of detention – they were confident that these issues would be resolved when they left the IRC.

Only one person had access to a helping service and expressed disappointment with this:

"the psychologist doesn't understand my feelings" [Interviewee B01]

Another interviewee reported that he was still waiting to see a psychiatrist after ***"several months"*** [Interviewee B16].

One interviewee stated that it took a month for his prescription for anti-depressant medication to be continued and another said that his medication for his depressive condition had not been reviewed in the seven months he had been at Brook House.

Three individuals stated that they would like the support of a counsellor to cope with their feelings of depression. None had asked for this service, one was concerned that any wait to access this service would result in a delay to the decision about his removal.

Three interviewees praised the work of the Gatwick Detainees Welfare Group, stating that they found it extremely helpful and supportive and one interviewee said the same about the G4S welfare officers.

Finally, one interviewee stated that people who were sent to the SCU for a couple of days because of concerns about their mental situation appeared to return to normal accommodation in a more distressed state.

Gaps in provision

It is clear that there are substantial gaps in mental health provision at the IRCs both for people with pre-existing mental health conditions and those whose emotional health has been adversely affected by the experience of indeterminate detention.

However, there appear to be opportunities to improve provision. We interviewed the Director of Secure Healthcare for G4S who has responsibility for all health care provision which has now gone in-house from the beginning of May 2012. She said she is very committed to improving the range and quality of mental health service provision and acknowledged that the resources available would need to be an increased to achieve this.

Similarly, the commissioners and providers of community based mental health services were also very committed to resolve existing problems relating to care pathways and to play a full part in helping to deliver a much wider range of services to detainees.

We set out our recommendations for improving mental health services in the final chapter of this report.

Substance Misuse

We investigated whether the needs of detainees with drug and/or alcohol problems were addressed. We discovered that neither IRC accepts detainees with established substance misuse problems since they do not provide substitute prescribing for those with opiate problems or have the facilities to support detoxification from alcohol. Our interviewees agreed that substance misuse was not a problem for Tinsley and Brook Houses, a view which was confirmed by our interview with the Clinical Substance Misuse lead for Secure Environments at the joint Home Office/Department of Health Offender Health team.

However, we subsequently learned that the Department of Health has allocated £260,000 to develop an substance misuse services at Brook and Tinsley. The introduction of such a service would obviously be likely to change the admission criteria described above.

Chapter 6: Conclusions and Recommendations

Introduction

There was a consensus amongst all interviewees that the general capacity, efficiency and quality of healthcare provided at Tinsley and Brook houses has improved steadily over recent years with most of the issues identified at inspections resolved, with the exception of the provision of mental health services which was widely agreed to be inadequate.

It proved impossible to assess the quality of health and social care provision at the Cedars for the simple reason that these services have not yet been utilised by enough detainees to make a useful assessment. Our interviews with staff at the Cedars lead us to believe that there are robust policies and protocols in place to deal with health and safeguarding issues.

In this concluding chapter, we first summarise the progress of Tinsley and Brook House against the recommendations in the most recent inspection reports. We then submit our conclusions about the quality of physical healthcare provision. We finish with an extensive section examining the current failures of mental health provision before making recommendations to improve the service to detainees in this area.

Progress on Inspection recommendations – Tinsley House

The most recent inspection of Tinsley House was conducted from 7 – 11 February 2011.

There were a number of recommendations which are detailed below, along with the responses made by healthcare staff. Those recommendations which relate to the provision of mental health services and general social care are not addressed here but in the concluding section of this chapter.

5.13 A clear programme of clinical audit should be in place and reviewed regularly.

Clinical audits are now reported to be undertaken regularly, with any audits undertaken discussed in nurse meetings.

5.14 Administrative support should be provided to release qualified nurses for professional duties in caring for detainees.

Following the transition to G4S integrated services on 1 May 2012, there is now a full-time practice manager in post; there is current recruitment to a part time admin support post. Both post holders will be based at Brook House but will also attend Tinsley on a daily basis.

5.15 All nursing staff should participate in a structured clinical supervision programme and have appropriate developmental opportunities.

Clinical supervision is now undertaken. A new Education Development and Resource (EDR) approach is being put in place which will promote appropriate training for each individual; the next stage is the development of the training matrix. Some training has already been organised with three nurses attending a triage course week beginning 28 May 2012.

5.16 A system should be in place in the health care department to monitor clinical incidents and the lessons learnt from these.

All clinical incidents are now reviewed quarterly at staff meetings. We have seen a medication incident report template.

Progress on Inspection recommendations – Brook House

The most recent inspection of Brook House was conducted from 12-23 September 2011 which was a follow-up to a full inspection undertaken in March 2010. There were a number of recommendations which are detailed below. Those recommendations which relate to the provision of mental health services and general social care are not addressed here but in the concluding section of this chapter.

5.33 The lead nurse manager should be more actively involved in the management of the health care centre and the development of all health care staff.

Since 1 May 2012 the lead nurse is now the Healthcare manager for all three sites with a deputy Nurse manager for backup. Both the Healthcare manager and deputy are now not included in the daily rotas allowing more time for this role to develop and support to be given to other staff members

5.34 The health care centre should be provided with a toilet for the use of detainees being examined or treated.

This recommendation was rejected owing to problems with the design of the building.

5.35 The security of the pharmacy room and administration hatch should be reviewed.

Security was reviewed immediately after the inspection, stronger catches have been fitted to the hatch and markings placed outside the door and Detention and Custody Officers advised that only one detainee should be in the marked area at a time

5.37 Adequate facilities should be provided for the management of detainees with disabilities who need enhanced care.

Healthcare state that the disabled rooms have been improved and that staff work closely with diversity officer for any specific needs. However, other interviewees state that facilities remain limited.

5.38 Nursing staff should be suitably qualified to deliver specialist clinics.

Nurses are trained but only three clinics currently run: clinics for diabetics and people with hypertension run at weekends and smoking cessation clinics when the trained member of staff is on duty.

5.39 Clinical supervision should be provided for all professional health care staff.

Clinical supervision is undertaken. The quality of supervision and support should be improved with the implementation of the EDR approach (see previous section).

5.41 All doors to the health care centre should be secured with a separate health care suite key.

All healthcare doors are now on a separate key and only given to healthcare staff.

5.42 The pharmacist should be supported to take a more active role within the centre, especially with regard to prescribing review and analysis.

The pharmacist attends once a month for a visit to the centre and attends any Drug therapeutic meeting/ now called Medicine management meetings. We have seen minutes of the most recent meeting on 9 May 2012.

5.44 All health care staff should be trained in the recognition and treatment of victims of torture.

All Nursing staff have attended the training on victims of torture provided by G4S.

5.45 Health care staff should be informed at the earliest opportunity of a detainee's pending release, transfer or removal.

UKBA now give a copy of the removal directions to healthcare as soon as they are set.

5.47 Regular out-of-date checks should be carried out on all medicines and records kept.

Monthly out of date checks are undertaken and records kept of medicines expired and destroyed.

5.48 The use of patient named medication should be encouraged where practicable.

The prescription of in-possession medication is increasing. There are plans to recruit a part-time pharmacy dispenser, current stage: development of job description.

5.49 There should be standard procedures to cover the current arrangements for pharmacy service provision and delivery of medication to detainees. These should be formally agreed through the medicines and therapeutics committee.

A standard operating procedure for the pharmacy has been written. G4S has recently (may 2012) issued guidance on "supporting safer prescribing in secure environments".

5.50 A medicines and therapeutics committee should meet at least four times a year. Meetings should have clear terms of reference and all relevant stakeholders should attend.

Medicine management meeting are undertaken quarterly and records are kept. We have seen minutes of the last meeting on 9 May 2012.

5.51 The system of relying on faxed prescriptions should be subject to audit.

The original prescriptions are sent to the pharmacist once the prescription has arrived to confirm the faxed copy.

Physical health

Generally, the provision of primary physical healthcare appears to be of good quality and is easily accessible. Without a clinical audit, it is not possible to assess the validity of the complaints of some detainees that their medical concerns are not dealt with thoroughly

but with the prescription of minor analgesics. However, large numbers of detainees appear to be receiving appropriate interventions for a wide range of conditions and we have no evidence to confirm that this is a significant problem.

The quality of healthcare provision could be further improved by paying attention to the following recommendations:

It is recommended that clinicians treating detainees with infectious diseases or concerned about outbreaks of this nature should work with the local Health Protection Unit to ensure IRC managers are given appropriate advice about the isolation of individuals and other infection control measures.[5]

It is recommended that consideration be given to improving the range of mobility aids available so that incapacitated detainees can access the range of services available.

It is recommended that the policy of providing only emergency dental care is revisited to ensure that detainees can access the same level of services available to UK citizens in the community.

It is recommended that detainees are made fully aware of the fact that they may exercise outside for several hours per day and are encouraged to do this and make full use of the gym facilities.

It is recommended that asylum seeking detainees[6] who are discharged to the community are informed about their eligibility to free healthcare as defined by NHS guidance issued on 29 May 2012[7], backed up by a leaflet in their first language.

Mental health

There is not access to a full range of mental health services at either IRC. The work of the RMN in post was commended by interviewees but one worker (+ an additional shift per

[5] The requirements for IRCs in relation to communicable diseases are covered under Healthcare Standard 26 in the Detention Services operating standards manual for immigration service removal centres: http://www.ukba.homeoffice.gov.uk/sitecontent/documents/managingourborders/immigrationremovalcentres/operatingstandards/operatingstandards_manual.pdf?view=Binary

[6] Detainees who have not been refused asylum status will have full access to NHS services.

[7] Implementing the Overseas Visitors Hospital Charging Regulations 2011 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127393

week) cannot meet the needs of 550 detainees across three facilities. Similarly, the input from outside agencies of one psychologist session per week (at Tinsley only) and one psychiatric consultant session per week is inadequate to meet need.

This provision is particularly important for four main reasons:

1. There is evidence in the literature that the experience of indeterminate detention in immigration centres is associated with a negative impact on mental health
2. There is a small but persistent proportion of detainees with pre-existing mental health problems, particularly relating to their experience of torture and other traumas.
3. Our study suggests that individuals with mental health problems remain in detention for twice the average length of stay.
4. The lack of provision results in the deterioration of the mental health problems of many detainees which may require more extensive and expensive interventions.

However, despite these concerns, there are also a considerable number of reasons for cautious optimism:

- There was a universal acknowledgement of these concerns and a high level of commitment towards improving service provision from all professional interviewees.
- G4S has taken the healthcare service in-house and is committed to improving the quality and range of mental health provision.
- Community-based commissioners and providers are committed to playing a full part in funding and delivering an improved mental health service in terms of both more effective care pathways and delivering an in-reach service which builds the capacity of in-house provision.
- The services provided by the Samaritans, the Gatwick Detainees Support Group and the in-house welfare services provided by G4S have the potential to be consolidated within an overall framework which aims to improve the quality of social care and emotional health services within the IRCs.
- Detainees at both Brook and Tinsley have good access to the Internet and could make use of the wide range of support forums and services that are available online.
- In the same way, the fact that all detainees have access to a mobile phone means that they can enjoy support from a wide range of families and friends both in the UK and their homeland.

- The clinical psychology service has particular expertise in dealing with trauma.

Recommendations

We have produced a set of recommendations which we feel can help develop the momentum needed to make substantive change in this area of provision.

Although West Sussex PCT has a responsibility for the medical care provided in local IRCs, it will clearly be important that the following recommendations are taken forward within a national context which would ideally ensure that the same quality of provision is commissioned and delivered across the immigration removal estate. It will be important to link in with the Department of Health's Clinical Professional Advisory Group which will be looking at mental health provision in IRCs in the near future.

It is recommended that ***the PCT and UKBA take joint responsibility for convening a high-level working group charged with improving the level of mental health provision across the West Sussex IRCs. We suggest that there should be membership from G4S at a senior management level and within the key disciplines operating at Brook and Tinsley (healthcare, safeguarding, welfare services and front-line Detention and Custody Officers); the commissioners and providers of mental health services in West Sussex; the clinical psychologist with a specialism in trauma; the Samaritans and the Gatwick Detainee Welfare Group.***

It is recommended that ***this working group agrees as a primary guiding principle that detainees should have access to an equivalent range and quality of services as would be available to an ordinary citizen in West Sussex via their GP.***

It is recommended that ***this working group ensures that proper protocols are in place for the assessment of individuals who may not be fit for detention.***

It is recommended that ***this working group agrees a series of quality standards of healthcare against which provision can be audited. The current UKBA contract with G4S for the provision of services at Brook and Tinsley House contains standards which can be used as a starting point for discussions. Discussions should include best mental health screening practice and incorporate NICE guidelines for the treatment of mental conditions.***

***It is recommended that** this working group agrees, as a matter of priority, a care pathway for detainees who require in-patient treatment including, in particular, a clear agreement as to funding responsibilities.*

***It is recommended that** this working group advises G4S on the most appropriate professional staff and skill-sets to be employed in increasing the in-house mental and emotional health provision.*

***It is recommended that** this working group develops a range of group and individual services which aim to help detainees cope with the experience of detention and develop emotional resilience which is of value to them both as detainees and on their return home. It should be noted that although group work provision can be very effective and relatively inexpensive, some detainees with experience of torture or other trauma or who do not possess sufficiently proficient English language skills will require individual interventions. It is likely that IAPT (or equivalent therapies provided by in-house RMNs) should be a key component within this provision.*

***It is recommended that** this working group develops a strategy to deliver general mental health awareness training for front-line staff and seeks to make best use of available courses both from within G4S and in West Sussex.*

***It is recommended that** UKBA and G4S explore how a small number of healthcare beds might be made available for detainees who are considered to be at high risk of self-harm or are in severe emotional distress. If this can be achieved, it would be a much more appropriate option than the current CSU.*

***It is recommended that** this working group convenes a smaller group to explore a wide range of online helping and peer support services and forums which detainees can access. It will be important to ensure that the needs of a wide range of ethnic groups are met and to put in place a site validation service which ensures that appropriate resources are not blocked by the necessary Internet security software. (One interviewee told us that some online resources which would be appropriate forms of support for detainees are inappropriately blocked. For instance, sites which offer advice and support for those struggling with depression and thoughts of self-harm are sometimes inadvertently blocked out of a fear that they are sites which are promoting self-harm or suicide.*

***It is recommended that** the working group develops a clear strategy for promoting this improved range of services and encouraging detainees to access them.*

We also have two other recommendations not relating to mental health provision at Brook and Tinsley.

It is recommended that ***the National Health Service Commissioning Board works with Public Health England to establish a working group to determine the most appropriate model for delivering the new substance misuse services. It will be important to liaise with Boards in other areas who are also developing substance misuse interventions in other IRCs.***

It is recommended that ***a group of key agencies responsible for delivering healthcare to children and families at Cedars should be convened to agree key standards and an appropriate service, in particular in relation to mental health and for pregnant mothers. Children and Adolescent Mental Health Services, Midwives and the Health Visiting service should be included in this working group.***